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TAILORING EMTALA TO BETTER PROTECT THE INDIGENT: THE SUPREME COURT PRECLUDES ONE METHOD OF SALVAGING A STATUTE GONE AWRY

*Michael J. Frank**

"[L]aws are not always effective simply because they are there."¹

INTRODUCTION

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA)² to stem the tide of patient dumping, the practice of refusing medical treatment to those unable to afford it.³ In drafting the statute, however, Congress used both vague and broad language,⁴ leaving courts to struggle with its interpretation. Some courts have interpreted the statute in order to regulate the conduct of

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¹ALEXANDER M. BICKEL, *THE MORALITY OF CONSENT* 106 (1975).

²See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, 100 Stat. 82 (codified as amended at 42 U.S.C. § 1395dd (1993)). Because EMTALA was part of the Consolidated Omnibus Reconciliation Act, it was previously, but is now infrequently, referred to as "COBRA."

³See *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 142 (4th Cir. 1996).

⁴For example, the statute protects "any individual" in that such individual is entitled to "an appropriate medical screening examination." 42 U.S.C. § 1395dd(a) (1994). As Judge Boggs of the Sixth Circuit eloquently noted: "'Appropriate' is one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation. Who, after all, can be found to stand up for 'inappropriate' treatment or actions of any sort?" *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

hospitals beyond the statute's intended scope, thereby invading areas traditionally left to state law.⁵ Specifically, EMTALA is being used as a federal medical malpractice statute, punishing hospitals for negligent or even innocent conduct.⁶

Unfortunately, this expansion of the statute comes at the expense of the Act's purpose. In an effort to prevent EMTALA from being used as a malpractice statute, thus intruding into the state common law domain, courts began crafting devices to limit the scope of EMTALA.⁷ One court has required plaintiffs to allege and prove that the physician or hospital acted with an improper motive.⁸ The Supreme Court has considered whether this motive requirement comports with the text of the statute, examining the statute for the first time since its enactment thirteen years ago. In *Roberts v. Galen of Virginia, Inc.*, the Court answered that question in the negative,⁹ but left open the question of whether other means of statutory limitations are compatible with the text of the statute.¹⁰

In the first section of this article, a brief overview of EMTALA is provided, which discusses the general terrain and technicalities of the

⁵See *Cherukuri v. Shalala*, 175 F.3d 446, 448 (6th Cir. 1999) (EMTALA's "literal language reaches well beyond its stated purpose"); *Vickers*, 78 F.3d at 144 (noting that certain interpretations of EMTALA would make it indistinguishable from state malpractice law).

⁶Thus, in nearly every decision, the courts remind the parties that "Congress did not intend the Act to be a substitute for a state malpractice action." *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 869 (4th Cir. 1994). Despite this admonition, parties continue to bring EMTALA/malpractice actions. See *Vickers*, 78 F.3d at 143 (An examination of both allegations reveals, however, that they ultimately present conventional charges of misdiagnosis, and that their reasoning would obliterate any distinction between claims of malpractice under state law and actions under EMTALA).

⁷For example, some courts required plaintiffs to prove that they were indigent, and held that those who could afford emergency medical treatment were outside the class protected by EMTALA. See *Cleland*, 917 F.2d at 268 (noting that the district court "found that it was unlikely that Congress intended for Sec. 1395dd to be used as a general malpractice action, because this statute addresses concerns about indigent patients rather than bringing within its ambit all unfortunate consequences that occurred to any and all patients"); *Coleman v. McCurtain Mem'l Med. Management, Inc.*, 711 F. Supp. 343, 348 (E.D. Okla. 1991); *Stewart v. Myrick*, 771 F. Supp. 433, 435-36 (D. Kan. 1990) (only indigent "persons denied emergency medical care possess a private cause of action under the Act"); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 498 (S.D. Ind. 1989) (summary judgment for hospital is proper where plaintiff presented no evidence that she was turned away from hospital for economic reasons).

⁸See *Cleland*, 917 F.2d at 272 (EMTALA's use of the term "appropriate" must more correctly be interpreted to refer to the motives with which the hospital acts).

⁹See *Roberts v. Galen of Va., Inc.*, 119 S. Ct. 685 (1999) (per curiam).

¹⁰*Id.*

statute as the courts have interpreted it. In addition, some of the controversies that have arisen in interpreting the Act are also discussed. The next section of the paper addresses the shortcomings of the *Roberts* decision. Finally, this paper explains the correctness of the Sixth Circuit's motivation for its *Roberts* opinion—preventing EMTALA from becoming a malpractice statute—despite its erroneous departure from the text of the statute. The article concludes, as many others have, that an amendment limiting the reach of EMTALA is in the best interest of the affected parties. Furthermore, regardless of congressional action on the matter, courts should limit the Act's indefinite scope.

EMTALA: AN OVERVIEW

American hospitals have a long history of providing emergency medical care to those in need, regardless of ability to pay.¹¹ As health care costs spiraled heavenward, some hospitals could no longer afford this practice, and refused to treat even emergency patients absent proof of ability to pay.¹² In the 1980s, society became more aware of this problem, commonly known as "patient dumping." Congress realized that more and more hospitals (primarily those with emergency rooms) were refusing to treat indigent patients when they discovered they had no insurance or alternative means of payment.¹³ Consequently, these patients either were refused treatment, or more commonly, were transferred to other health care facilities.¹⁴ At a minimum, this practice

¹¹See *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990); *Smith v. Richmond Mem'l Hosp.*, 416 S.E.2d 689, 691 (Va. 1992).

¹²See *Smith*, 416 S.E.2d at 691.

¹³It should be noted that long before EMTALA, the common law of several states already recognized a duty to afford medical treatment in emergencies. See *Valdez v. Lyman-Roberts Hosp., Inc.*, 638 S.W.2d 111, 114 n.1 (Tex. App. 1982); *Richard v. Adair Hosp. Found. Corp.*, 566 S.W.2d 791, 793 (Ky. App. 1978); *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1331 (Ariz. 1975); *Mercy Med. Ctr. of Oshkosh, Inc. v. Winnebago County*, 206 N.W.2d 198, 200 (Wisc. 1973); *Stanturf v. Sipes*, 447 S.W.2d 558, 561 (Mo. 1969); *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961); see generally Jonathan M. Purver, Annotation, *Liability of Hospital for Refusal to Admit or Treat Patient*, 35 A.L.R.3d 341 (1971).

¹⁴See H.R. REP. NO. 99-241(I), reprinted in 1986 U.S.C.C.A.N. 579, 605. The Report states: "The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if

resulted in the worsening of the patients' respective conditions,¹⁵ and sometimes even resulted in death.

Seeking to eradicate dumping, Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. Through this statute, Congress sought to have individuals with emergency conditions examined and treated "according to an assessment of their medical needs, without regard to extraneous considerations such as their ability to pay."¹⁶ But the extent to which EMTALA has successfully achieved its noble goal is questionable,¹⁷ as patient dumping continues.¹⁸ Importantly, Congress did not provide financing for the added burdens the Act placed on hospitals.¹⁹

EMTALA is far-reaching and applies to all hospitals that participate in the federal medicare program.²⁰ With respect to the Act's requirement that hospitals screen patients to determine whether an emergency medical condition exists, only those hospitals which have an emergency department are governed by EMTALA.²¹ This latter caveat has led some hospitals to avoid EMTALA's reach and its

the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately." *Id.*

¹⁵See *Miller v. Medical Ctr. of S.W. La.*, 22 F.3d 626, 627 (5th Cir. 1994). In *Miller*, the patient required care from a specialist, but was denied treatment after the hospital administrator learned that he had no insurance. Eventually, another hospital agreed to accept him, but the initial refusal resulted in a delay of seven hours, purportedly causing the patient's condition to worsen. *See id.*

¹⁶*Vickers*, 78 F.3d at 144; *see Brooks v. Maryland Gen. Hosp.*, 996 F.2d 708, 711 (4th Cir. 1993).

¹⁷See Lawrence E. Singer, *Look What They've Done to My Law, Ma: COBRA's Implosion*, 33 HOU. L. REV. 113, 117 (1996).

¹⁸See *Luckey v. Gioia*, 496 S.E.2d 539, 540 (Ga. Ct. App. 1998) (recounting an episode of patient dumping).

¹⁹See Daniel N. Rosenstein, *Emergency Stabilization for a Wounded COBRA*, 9 ISSUES L. & MED. 255, 293 (1993) (suggesting that Congress reimburse hospitals for the costs of EMTALA).

²⁰See 42 U.S.C. § 1395dd(e)(2) (1994). This is not much of a limitation, as most hospitals participate in the "federal Medicare program – a lucrative source of institutional revenue." *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1189 (1st Cir. 1995). For a brief discussion of purported ways in which managed care organizations evade EMTALA duties see John A. Marx, *Emergency Medicine*, 277 JAMA 1851, 1851 (1998).

²¹See 42 U.S.C. § 1395dd(a) (1994); *Brooks*, 996 F.2d at 715 (EMTALA imposes "limited duty on hospitals with emergency rooms"); *Abercrombie v. Osteopathic Hosp. Founders Ass'n*, 950 F.2d 676, 680 (10th Cir. 1991) (COBRA applies to any hospital that receives Medicare payments and has an emergency department).

associated expenses, at least for the screening requirement, by closing their emergency rooms.²²

While a hospital's duty to screen arises when an individual "comes to the emergency department,"²³ courts have differed on EMTALA's applicability to patients seeking treatment at other hospital departments. The text of the statute indicates that the duty to stabilize an emergency condition arises whenever an individual "comes to a hospital,"²⁴ and the duty to transfer arises if an individual is "at a hospital."²⁵ "When Congress includes particular language in one statutory provision, and excludes it in another [courts] generally assume that Congress did so intentionally."²⁶ Thus, because Congress omitted the words "emergency department" from EMTALA's specification that patients be stabilized before transfer, Congress intended that a hospital stabilize a patient's emergency medical condition even when an individual comes to another department of the hospital. This would include hospital visits for routine examination or extended treatment, and not just for emergency treatment in the emergency room.²⁷ The text compels this interpretation,²⁸ and failing to

²²See RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 95 (1997) (noting that hospitals can "reduce their statutory exposure by shrinking their ER capacity or closing it altogether"). Whether EMTALA has had a direct effect is unclear, but since the passage of the Act, more than 700 hospitals have eliminated or substantially downsized their emergency care departments. See *id.* at 97.

²³42 U.S.C. § 1395dd(a) (1994); see *Rios v. Baptist Mem'l Hosp. Sys.*, 935 S.W.2d 799, 803 (Tex. App. 1996) (While we agree that basing a decision upon which door a patient entered seemingly places form over substance ... a failure to screen claim requires presentment in the emergency department).

²⁴42 U.S.C. § 1395dd(b)(1) (1994).

²⁵42 U.S.C. § 1395dd(c)(1) (1994).

²⁶*Uniroyal Chem. Co., Inc. v. Deltech Corp.*, 160 F.3d 238, 244 n.9 (5th Cir. 1998) (citing *Russello v. United States*, 464 U.S. 16, 23 (1983); *United States v. Wong Kim Bo*, 472 F.2d 720, 722 (5th Cir. 1972) ([W]here Congress has carefully employed a term in one place and excluded it in another, it should not be implied where excluded)).

²⁷See *Lopez-Soto v. Hawayek*, 175 F.3d 170, 173 (1st Cir. 1999); *Urban*, 43 F.3d at 524; *Reynolds v. Mercy Hosp.*, 861 F. Supp. 214, 222 (W.D.N.Y. 1994) (plaintiff admitted by private physician for pre-arranged surgical procedure); *McIntyre v. Schick*, 795 F. Supp. 777, 781 (E.D. Va. 1992) (to state a claim for failure to stabilize, a plaintiff need not allege that she sought treatment at the hospital's emergency room, but only that she sought treatment at the hospital); *Helton v. Phelps County Reg'l Med. Ctr.*, 794 F. Supp. 332, 333 (E.D. Mo. 1992); *Smith*, 416 S.E.2d at 690 (plaintiff admitted to hospital when physician ordered his transfer).

²⁸See *Smith*, 416 S.E.2d at 692 (comparing the statutory language of the various sections). This interpretation also seems consistent with the legislative purpose. As the court

properly interpret the statute creates some curious results.²⁹ The absurdity of a contrary reading can be demonstrated by considering the case of an unborn infant whose mother was admitted to the obstetrics department. Clearly the child has not come to the hospital's emergency department. Under a narrow reading of EMTALA, once the infant is born, a hospital would have no duty under EMTALA to treat any emergency medical condition from which the infant might suffer.³⁰ This conclusion rests on the fact that the infant did not seek emergency treatment in the emergency room (although his mother may have).

To prevent this and other absurd results, several courts have held that expectant mothers admitted to the obstetrics departments of hospitals and their unborn children are entitled to emergency medical treatment under EMTALA despite the fact that they are not seeking aid at the emergency room.³¹ This arguably serves EMTALA's purposes by preventing a hospital from dumping uninsured patients who come to the hospital for non-emergency treatment, but who later need expensive, emergency treatment.³² Other courts reject this interpretation and hold that the duty to stabilize (and not to transfer before stabilization) arises only when a patient comes to the emergency room with an emergency medical condition.³³ These courts base their

in *Smith* stated: "Patient dumping is not limited to a refusal to provide emergency room treatment." *Id.*

²⁹See *United States v. Mack*, 164 F.3d 467, 472 (9th Cir. 1999).

³⁰See *Loss v. Song*, No. 89-C-6952, 1990 WL 159612, at *1, 3 (N.D. Ill. Oct. 16, 1990) (finding that an infant born with an emergency medical condition is protected by EMTALA's stabilization requirement even though he never sought admission to the emergency room).

³¹See *Lopez-Soto*, 175 F.3d at 173; *Urban*, 43 F.3d at 524 (plaintiff alleging failure to stabilize claim originally sought treatment at the hospital's obstetrics department); *Smith*, 416 S.E.2d at 690 (plaintiff admitted to hospital which transferred her to another hospital after she developed an emergency medical condition).

³²According to a panel of the First Circuit:

[P]atient dumping is not limited to emergency rooms. If a hospital determines that a patient on a ward has developed an emergency medical condition, it may fear that the costs of treatment will outstrip the patient's resources, and seek to move the patient elsewhere. That strain of patient dumping is equally pernicious as what occurs in emergency departments, and we are unprepared to say that Congress did not seek to curb it.

Lopez-Soto, 175 F.3d at 177.

³³See *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996) (after stabilizing patient and treating her for twenty days, hospital had no duty to resuscitate her

opinions on the idea that EMTALA was originally designed to prevent the dumping of patients seeking treatment at the emergency room, and its function is not to regulate a hospital's treatment of a patient indefinitely.

Under EMTALA, a patient "comes to the emergency department" when the individual arrives on the hospital property and he or someone on his behalf requests an examination or treatment.³⁴ Merely entering the emergency department with an injury and asking for the location of the admissions office is not a request for treatment.³⁵ EMTALA only imposes a duty on hospitals when a request is made for examination or treatment. With respect to arriving on hospital property, a recent case in Chicago underscores that the individual need not enter the hospital. In 1999, Ravenswood Hospital Medical Center was fined \$40,000 by the federal government for failing to treat a gunshot victim who was brought just beyond the hospital entrance.³⁶ A patient is also considered to have come to the emergency department when a hospital-owned ambulance is transporting her, regardless of whether the ambulance is physically at the hospital.³⁷ Non-hospital-owned ambulance companies are not directly liable under EMTALA.³⁸

under EMTALA); *James v. Sunrise Hosp.*, 86 F.3d 885, 889 (9th Cir. 1996) (the subsection (c) transfer restrictions apply only to patients who go to the emergency room); *Miller*, 22 F.3d at 628 (duty to screen and stabilize is only triggered when an individual comes to the emergency department); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990) (plaintiff must allege that she went to emergency room); see *Lopez-Soto v. Hawayek*, 20 F. Supp. 2d 279, 282 (D.P.R. 1998) (plaintiff must show that she sought treatment at emergency room, not merely that she entered the hospital through emergency room door), *rev'd*, 175 F.3d 170 (1st Cir. 1999); *Arrington*, 19 F. Supp. 2d at 1154; *Fisher v. New York Health & Hosp. Corp.*, 989 F. Supp. 444, 448 (E.D.N.Y. 1998) (for both failure to screen and stabilize claims "a plaintiff must allege that he went to the emergency room"); *Owens v. Presbyterian Hosp.*, No 94-Civ-6004, 1995 WL 464950, at *1 (S.D.N.Y. Aug. 4, 1995); *Huckaby v. East Alab. Med. Ctr.*, 830 F. Supp. 1399, 1402 (M.D. Ala. 1993).

³⁴See 42 U.S.C. § 1395dd(a) (1994); *Miller*, 22 F.3d at 628; *Hernandez v. Starr County Hosp. Dist.*, 30 F. Supp. 2d 970, 972 (S.D. Tex. 1999).

³⁵See *Rios*, 935 S.W.2d at 804.

³⁶*Laura Meckler, Chicago Hospital Fined for Ignoring Shooting Victim*, STATE J. REG., Mar. 13, 1999, at 8.

³⁷See *Stevison v. Enid Health Care Sys., Inc.*, 920 F.2d 710, 713 (10th Cir. 1990) ([H]ospital must provide screening if a request is made); *Hernandez v. Starr County Hosp. Dist.*, 30 F. Supp. 2d 970, 972 (S.D. Tex. 1999); 42 C.F.R. § 489.24 (1993).

³⁸MIKEL A. ROTHENBERG, EMERGENCY MEDICAL MALPRACTICE § 1.12 (2d ed. Supp. 1997).

Communication with the hospital either by phone or a telemetry system does not constitute "[coming] to the emergency department."³⁹ Thus, a hospital's duty to examine a patient for an emergency medical condition arises only for patients who present themselves at the emergency room and request an examination.⁴⁰ The duty to stabilize a patient's emergency medical condition arises when a patient merely "comes to a hospital."⁴¹

Because EMTALA was designed to prevent dumping of indigent patients, initially some courts interpreted the statute to apply only to those individuals who could not afford medical care.⁴² However, among the Courts of Appeals, a consensus has developed that Congress's use of the term "any individual" means that EMTALA protects any individual, regardless of whether he is indigent.⁴³ EMTALA requires hospitals to examine any patient presented at their emergency rooms to ascertain his medical needs, and to stabilize any emergency medical conditions before releasing or transferring him.⁴⁴

Thus, there are two basic requirements under EMTALA:⁴⁵ a medical screening requirement to determine whether the individual has

³⁹See *Miller*, 22 F.3d at 630; *Johnson v. University of Chicago Hosp.*, 982 F.2d 230, 233 (7th Cir. 1992) (per curiam) (telemetry system); *Arrington v. Wong*, 19 F. Supp. 2d 1151, 1156 (D. Haw. 1998) (ambulance communicated with hospital by radio).

⁴⁰See *Lopez-Soto*, 175 F.3d at 173 (Clearly, this provision obligates hospitals to screen only those individuals who present themselves at the emergency department); *Campbell v. Westchester County*, No. 96-Civ-0467, 1998 WL 788791, at *3 (S.D.N.Y. Nov. 10, 1998) (EMTALA imposes no duty to screen where patient presented himself to outpatient department pursuant to pre-arranged follow-up appointment).

⁴¹See 42 U.S.C. § 1395dd(b)(1) (1994).

⁴²See *Cleland*, 917 F.2d at 268; *Coleman*, 771 F. Supp. at 348; *Stewart*, 731 F. Supp. at 435-36; *Evitt*, 727 F. Supp. at 498; *Boudreaux v. State*, 687 So. 2d 596, 598, 599 (La. Ct. App. 1997); *Di Gicomio v. St. Joseph's Hosp. & Health Ctr.*, 582 N.Y.S. 2d 887, 888 (N.Y. App. Div. 1992).

⁴³See 42 U.S.C. § 1395dd(a) & (b) (1994); *Correa*, 69 F.3d at 1194 (EMTALA covers all patients regardless of insurance status or ability to pay); *Power*, 42 F.3d at 857; *Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1373 (5th Cir. 1991); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991); *Cleland*, 917 F.2d at 268 (We hold Congress to its words, that this statute applies to any and all patients); *Lee v. Alleghany Regional Hosp. Corp.*, 778 F. Supp. 900, 902 (W.D. Va. 1991) (it is not the job of this court to rewrite a statute, based upon legislative history, when the plain words are unambiguous). Notably, the panel in *Gatewood* included two present Supreme Court Justices: Clarence Thomas and Ruth Bader Ginsburg.

⁴⁴As shown below, the hospital has a duty to stabilize the patient before transferring or discharging him regardless of whether the patient first appears at the emergency room.

⁴⁵*Vickers*, 78 F.3d at 142; *Correa*, 69 F.3d at 1190; *Urban*, 43 F.3d at 525.

an emergency medical condition,⁴⁶ and a stabilization or transfer requirement, if it is determined that the individual is in labor or has an emergency medical condition.⁴⁷ More specifically, EMTALA proscribes five general evils:

- (1) failure to appropriately screen a patient for an emergency medical condition within the hospital's capabilities;⁴⁸
- (2) failure to stabilize a patient before transferring⁴⁹ him (which includes discharging him) when the hospital knows that he has an emergency medical condition;⁵⁰
- (3) failure to appropriately transfer⁵¹ a patient when the individual so requests or when her physician believes that she will benefit from a transfer to another facility;⁵²
- (4) refusing to accept a transferred patient;⁵³ and

⁴⁶See 42 U.S.C. § 1395bb(a) (1994).

⁴⁷See 42 U.S.C. § 1395dd(b) (1994).

⁴⁸See 42 U.S.C. § 1395dd(a) (1994); *Vickers*, 78 F.3d at 142.

⁴⁹The provisions related to a transfer ordered by a physician can be violated in at least four ways: (1) failing to obtain the treating physician's signature on the certification form; (2) failing to weigh the risks and benefits of transfer; (3) considering improper factors in making the transfer; and (4) making the transfer without summarizing the risks and benefits of the transfer. See 42 U.S.C. § 1395(c)(1)(A)(ii)-(iii); *Vargas v. Del Puerto Hosp.*, 98 F.3d 1202, 1204 (9th Cir. 1996) (doctor failed to summarize risks and benefits of transfer on certification form); *Burditt*, 934 F.2d at 1371. Of course, a plaintiff still must show harm directly resulting from these violations to prevail in a civil suit.

⁵⁰See 42 U.S.C. § 1395dd(b)(1)(A) (1994); *Barber*, 977 F.2d at 883. Like other corporate entities, a hospital obviously cannot have knowledge. So, as with corporations, the knowledge of the agents is imputed to the principal. See *Federal Kemper Ins. Co. v. Brown*, 674 N.E.2d 1030, 1033 (Ind. Ct. App. 1997) (the law imputes an agent's knowledge, acquired while the agent was acting within the scope of his agency, to the principal, even if the principal does not actually know what the agent knows). But see *People v. Kleiner*, 664 N.Y.S.2d 704, 708 (N.Y. Sup. Ct. 1997) (for violation of New York criminal statute, medical practitioner need not have actual knowledge that the person refused treatment was in need of emergency medical treatment).

⁵¹An appropriate transfer entails sending the patient to a facility with adequate space and which has agreed to the transfer, via proper transportation equipment under the supervision of qualified personnel. See 42 U.S.C. § 1395dd(c)(2) (1994). It also entails transferring relevant medical records. See 42 U.S.C. § 1395dd(c)(2)(C) (1994); *Dickey v. Baptist Mem'l Hosp.-North MS*, 146 F.3d 262, 264 (5th Cir. 1998) (EMTALA claim for failing to transfer x-rays and radiology reports).

⁵²See 42 U.S.C. § 1395dd(b)(1)(B) & (c) (1994). In some respects, this provision is an example of the way in which the language of EMTALA can regulate behavior for which it was not designed. Conceivably, a hospital could violate EMTALA for failing to transfer a patient, not because the patient was impecunious, but because the patient had an abundance of means which the hospital desired to keep for itself.

- (5) delaying the screening, stabilization, or transfer of a patient in order to inquire about his ability to pay.⁵⁴

Of course, a patient may refuse treatment or decide to leave before the hospital can ascertain his condition.⁵⁵ Even under these circumstances, however, EMTALA requires the hospital to take "all reasonable steps" to obtain the patient's written informed refusal to be treated or examined.⁵⁶ Moreover, in civil cases where a patient requested medical assistance (although the hospital contended that he refused treatment), the hospital has the difficult burden of proving that the request for treatment was withdrawn.⁵⁷

A violation of EMTALA entails serious financial and legal consequences. For hospitals and physicians, failure to screen or stabilize patients can result in a maximum civil fine of \$50,000 for each illegal act.⁵⁸ Where continuous and flagrant abuses are found, hospitals and physicians may be precluded from participating in government-funded health care programs.⁵⁹ As an added incentive to comply with the Act, hospitals (but not physicians) are subject to private suits for violations of EMTALA.⁶⁰ Congress also recognized that since "most screening and transferring, as defined under the statute, will be done by emergency room physicians, these physicians play a central role in enforcing the statutory provisions..."⁶¹ Therefore, EMTALA prohibits hospitals from retaliating against physicians and other health care

⁵³See 42 U.S.C. § 1395dd(g) (1994). This subsection, along with subsection (h), was added in the 1989 amendments to the statute. See Pub. L. 101-239, 103 Stat. 2106 (1989).

⁵⁴See 42 U.S.C. § 1395dd(h) (1999); 42 C.F.R. § 489.24(c)(3) (1998). Despite this provision, some hospitals continue to evaluate emergency patients' ability to pay before treating them. See *Correa*, 69 F.3d at 1188; *Miller*, 22 F.3d at 627. Notably, mere delay in screening can result in a finding that a medical screening evaluation was denied. See *Correa*, 69 F.3d at 1194 ("[W]e recognize that an emergency room cannot serve everyone simultaneously. But we agree with the court below that the jury could rationally conclude...that the Hospital's inaction here amounted to a deliberate denial of screening.").

⁵⁵See *Stevison*, 920 F.2d at 713 ("[A] hospital has satisfied its obligations under the statute if the patient refuses to consent to treatment.").

⁵⁶See 42 U.S.C. § 1395dd(b)(2) & (3); 42 C.F.R. § 489.24(c)(2).

⁵⁷See *Stevison*, 920 F.2d at 713-14.

⁵⁸See 42 U.S.C. § 1395dd(d)(1) (1994).

⁵⁹See *id.*

⁶⁰See 42 U.S.C. § 1395dd(d)(2)(A) (1994).

⁶¹JUDITH WAXMAN & MOLLY McNULTY, ACCESS TO EMERGENCY MEDICAL CARE: PATIENT'S RIGHTS AND REMEDIES 67 (1991)

workers who uphold the transfer provision.⁶² Similarly, whistleblowers on the hospital's staff who report violations of the statute are also protected under the Act.⁶³

Medical Screening Examination

As previously mentioned, EMTALA requires hospitals with emergency departments to provide patients with a screening examination to determine whether they suffer from an emergency medical condition.⁶⁴ This examination must not be delayed in order to inquire into the patient's financial or insurance status.⁶⁵ The Act imposes strict liability on hospitals for failing to perform at least a minimal examination within the hospital's capabilities.⁶⁶ Yet many commentators have noted that the law provides little guidance regarding what constitutes a screening exam.⁶⁷ Legal authorities are split on whether the quality of a hospital's screening examination must meet an objectively reasonable

⁶²See 42 U.S.C. § 1395dd(i) (1994). Interestingly, EMTALA does not expressly prohibit hospitals from retaliating against physicians who elect to comply with EMTALA's screening provision.

⁶³See 42 U.S.C. § 1395dd(i) (1994). The provision states:

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

⁶⁴See 42 U.S.C. § 1395dd(a) (1994).

⁶⁵See 42 U.S.C. § 1395dd(h) (1994).

⁶⁶See *Abercrombie*, 950 F.2d at 681; *Stevison*, 920 F.2d at 713 (We construe this statute as imposing a strict liability standard subject to those defenses available in the act); *Hutchinson v. Greater S.E. Community Hosp.*, 793 F. Supp. 6, 8 (D.D.C. 1992); *Clark v. Baton Rouge Gen. Med. Ctr.*, 657 So. 2d 741, 745 (La. Ct. App. 1995). Liability is "strict" in the sense that the hospital or agents need not have an evil motive or knowledge that the patient has an emergency medical condition to be held liable for failing to screen the patient. See, e.g., *Contract Courier Servs., Inc. v. Research & Special Programs Admin.*, 924 F.2d 112, 114 (7th Cir. 1991) (strict liability offense does not require that offender had knowledge that he was violating the law.); *United States v. Carmany*, 901 F.2d 76, 78 n.2 (7th Cir. 1990) (firearms statute imposes strict liability in that it does not require knowledge that the firearms were unregistered); *O'Neil v. Picillo*, 883 F.2d 176, 182 (1st Cir. 1989) ("CERCLA is a strict liability statute, so appellants could be held liable despite their lack of knowledge").

⁶⁷Gerald A. Williams, *How You Could Get Nailed for Patient Dumping*, MED. ECON. Apr. 13, 1998, at 189.

standard.⁶⁸ Failing to mandate an objective standard may result in hospitals routinely conducting cursory screening examinations. While hospitals may avoid liability under EMTALA with these practices, the emergency patients may suffer dangerous consequences.⁶⁹ Concerns about hospitals evading liability simply by providing shoddy screening examinations led the First Circuit to hold that a "hospital fulfills its statutory duty to screen patients in its emergency room if it provides for a screening examination *reasonably calculated to identify critical medical conditions* that may be afflicting symptomatic patients..."⁷⁰ Similarly, the Ninth Circuit held that "a medical screening examination is 'appropriate' if it is designed to identify acute and severe symptoms that alert the physician of the need for immediate medical attention to prevent serious bodily injury."⁷¹ Furthermore, the Fifth Circuit has stated that "a complete failure to attend to a patient who presents a condition that practically everyone knows may indicate an immediate and acute threat to life constitutes a denial of an appropriate medical screening examination."⁷² Accordingly, that court held that EMTALA required "a screening examination reasonably calculated to identify critical medical conditions..."⁷³

The District of Columbia, Sixth, Eighth, Tenth, and Eleventh Circuits, along with several states, construe the statute differently. They base their statutory interpretation on the plain meaning of the text

⁶⁸See *Trivette v. North Carolina Baptist Hosp.*, 507 S.E.2d 48, 51 n.1 (N.C. Ct. App. 1998) (recognizing the debate among the courts concerning whether a hospital's screening standard can be so minimal as to constitute a violation of EMTALA).

⁶⁹See *Baber*, 977 F.2d at 879 n.7 (discounting the theoretical possibility that hospitals might endanger all of their patients by performing uniformly abbreviated examinations on patients) (citing Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186 (1986)); See *James*, 86 F.3d at 889 ("[W]e are not accepting the proposition that, so long as the hospital does so bad a job that it never even spots emergencies, it cannot be liable.").

⁷⁰*Correa*, 69 F.3d at 1192 (emphasis added); see *Deberry*, 741 F. Supp. at 1305 (hospital is liable for "failing to detect the nature of the emergency condition through inadequate screening procedures"). But see *Marshall*, 134 F.3d at 323 ("a treating physician's failure to appreciate the extent of the patient's injury or illness as well as a subsequent failure to order an additional diagnostic procedure...cannot support an EMTALA claim for inappropriate screening").

⁷¹*Eberhardt*, 62 F.3d at 1257. At the same time, the court recognized that EMTALA does not impose a national standard of care in screening patients. See *id.* at 1258.

⁷²*Correa*, 69 F.3d at 1193.

⁷³*Id.* at 1192.

and EMTALA's recognized purpose (preventing patient dumping), neither of which support the view that Congress intended to create a national standard of emergency care.⁷⁴ Hoping to prevent EMTALA from becoming a malpractice statute, these Circuits have held that courts should not look into the efficacy of the medical procedures performed. Rather, the courts should only address the question of whether the hospital's procedures are uniformly followed, regardless of a patient's insurance status or other non-medical factors.⁷⁵ Thus, EMTALA is designed to prevent disparate treatment, rather than incorrect diagnoses.⁷⁶ These courts recognize that,

"EMTALA" is implicated only when individuals who are perceived to have the same medical conditions receive disparate medical treatment. It is not implicated when individuals who turn out, in fact to have had the same condition receive disparate treatment. The cornerstone of an "EMTALA" claim is the disparate treatment of individuals perceived to have the same conditions....The act is intended not to ensure each emergency room patient a correct diagnosis, but rather to ensure that each is afforded the same level of treatment regularly provided to patients in similar medical circumstances.⁷⁷

⁷⁴See *Baber*, 977 F.2d at 880 (the "avowed purpose of EMTALA was not to guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care"). But even the Fourth Circuit in *Baber* interpreted EMTALA as requiring a certain minimum care in medical screening examinations: EMTALA "requires hospitals to develop a screening procedure designed to identify such critical conditions that exist in symptomatic patients..." *Id.* at 879. In *Power*, the Fourth Circuit moved even closer to the malpractice standard of the First, Fifth, and Ninth Circuits. See *id.* at 858 (recognizing that its standard "blurs the line somewhat between a malpractice claim and an EMTALA claim").

⁷⁵See *Marshall*, 134 F.3d at 322 (adequacy is not judged by proficiency of examination); *Summers*, 91 F.3d at 1137; *Vickers*, 78 F.3d at 142; *Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994) ("Section 1395dd(a) does not require a hospital to provide a medical screening in the abstract, but one that is appropriate 'within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department.' Thus, the statute's requirement is hospital-specific, varying with the specific circumstances of each provider."); *Holcomb v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); *Baber*, 977 F.2d at 879; *Collins v. DePaul Hosp.*, 963 F.2d 303, 307 n.5 (10th Cir. 1992); *Gatewood*, 933 F.2d at 1039; *Cleland*, 917 F.2d at 271.

⁷⁶See *McIver v. Hospital of St. Raphael*, No. CV-980414154, 1999 WL 395391, at *1 (Conn. Super. Ct. June 7, 1999).

⁷⁷*Id.* The court went on to state: "Faulty screening in a particular case, as opposed to disparate screening or no screening at all does not violate the statute." *Id.*

Under this view, a violation of EMTALA occurs only if the patient's treatment differed from that provided to other patients.⁷⁸ Accordingly, the quality and adequacy of the screening procedure are governed by state malpractice law, and not EMTALA.⁷⁹ Some courts have even held that the hospital is not required to show that it had a uniform or written screening procedure.⁸⁰ This holding benefits hospitals hoping to prevent litigation because written protocols foster lawsuits in which plaintiffs claim that hospitals should have followed one procedure instead of another.⁸¹ Written policies also result in legal disputes about the meaning of key phrases in the policies.⁸² Moreover, the lack of a written policy makes it more difficult to prove that a hospital failed to adhere to that protocol.⁸³ As to the concern that this disparate treatment standard might encourage hospitals to implement uniformly deficient screening procedures, the courts have noted that state malpractice law should adequately guard against this result. Thus, when faced with this issue, one court explained:

[P]laintiffs argue that if I accept defendants' contention that all EMTALA requires is uniform treatment, then hospitals could avoid all liability under the statute by the simple expedient of implementing uniform, cursory and substandard screening procedures. This argument does not concern me. Compliance with EMTALA is not a defense to a malpractice

⁷⁸See *Marshall*, 134 F.3d at 319; *Blake v. Richardson*, No. 98-2576, 1999 WL 319082, at *2 (D. Kan. Apr. 1, 1999).

⁷⁹See *Trivette v. North Carolina Baptist Hosp.*, 507 S.E.2d 48, 51 (N.C. Ct. App. 1998).

⁸⁰See *Marshall*, 134 F.3d at 319; *Williams v. Birkeness*, 34 F.3d 695, 697 (8th Cir. 1994).

⁸¹See *Dinkins v. Hutzel Hosp., Inc.*, Nos. 94-1643, 94-1683, 1996 WL 38229, at *9 (6th Cir. Jan. 30, 1996) ("Dinkins argues that Children's has a protocol in place that required special treatment for a child with sickle cell disease...and that the hospital's failure to implement this protocol constitutes a violation of EMTALA").

⁸²See *Cunningham v. Fredonia Reg'l Hosp.*, No. 95-3350, 1996 WL 584917, at *2 (10th Cir. 1996) (plaintiff argued that the hospital should have followed its "Initial E.R. Care For Patient With Chest Pain" policy instead of its "Determination of Valid Emergency Illness/Injury" policy, and that the text of Chest Pain policy was ambiguous).

⁸³See *Power*, 42 F.3d at 858 (noting difficulties of proving failure to screen case when the hospital claims that it has no screening policy); *Griffith v. Mount Carmel Med. Ctr.*, 831 F. Supp. 1532, 1542 (D. Kan. 1993) (the hospital argued that because it had no standard screening policy, the testimony by the treating doctor that he treated the plaintiff as he would any other patient warranted summary judgment for the defendant).

claim, and I expect that even if a hospital were sufficiently venal that it would consider endangering its emergency room patients in this way, it would not likely risk exposure to state law malpractice claims by implementing shoddy across-the-board screening examinations.⁸⁴

Eschewing the two approaches mentioned above, the Fourth Circuit has adopted a middle position that utilizes a *McDonnell Douglas*⁸⁵ type of burden-shifting.⁸⁶ It first requires a plaintiff to establish a *prima facie* case of disparate treatment, she must show that in being screened she was treated differently from other similarly situated individuals.⁸⁷ Once the plaintiff makes this showing the hospital has the burden of producing evidence to show uniformity in its treatment of the plaintiff and similarly situated patients.⁸⁸ If the hospital succeeds, the plaintiff may submit evidence that the physician's medical judgment was defective as it was exercised in the medical screening.⁸⁹ As the Fourth Circuit stated:

We believe that the best approach, and the standard that we now adopt, is to allow a hospital, after a plaintiff makes a threshold showing of differential treatment, to offer evidence rebutting that showing either by demonstrating that the patient was accorded the same level of treatment that all other patients receive, or that a test or procedure was not given because the physician did not believe that the test was reasonable or necessary under the particular circumstances of that patient.

⁸⁴*Fisher*, 989 F. Supp. at 450.

⁸⁵*See McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973).

⁸⁶*See Power*, 42 F.3d at 858. This burden-shifting analysis differs from the traditional *McDonnell Douglas* framework used in employment discrimination cases in several important ways. For example, the *Power* burden-shifting is not designed to prove intentional discrimination (although it might lead to that conclusion), and it apparently does not drop out of the case once it is submitted to a jury. *See Wilson v. AM Gen. Corp.*, 167 F.3d 1114, 1123 (7th Cir. 1999) (Manion, J., concurring) ("[O]nce a discrimination case has been submitted to the jury, the *McDonnell-Douglas* burden-shifting analysis drops out of the picture").

⁸⁷*See Power*, 42 F.3d at 858.

⁸⁸*See id.* The court gave no indication that the hospital ever has a burden of persuasion.

⁸⁹*See id.*

If a hospital offers such rebuttal evidence, fairness dictates that the plaintiff should be allowed to challenge the medical judgment of the physicians involved through her own expert medical testimony.⁹⁰

But the court acknowledged that this approach was blurring the line between a malpractice claim and an EMTALA claim.⁹¹

Under all three approaches, though, the primary evil sought to be eradicated by the screening requirement is disparate treatment, failing to provide the same quality or quantity of examination to all patients.⁹² Under EMTALA, therefore, a patient can always assert a failure to screen claim when a hospital did not follow its usual screening examination procedures with similarly situated patients.⁹³ Of course, the patient has the burden of proving disparate treatment.⁹⁴ Under the majority approach, a screening examination procedure that is applied evenly, however, need not result in a correct diagnosis.⁹⁵

Under the most plausible interpretation of EMTALA, then, a hospital provides an adequate screening when it performs its usual screening practices in a uniform manner,⁹⁶ whether or not it effectively

⁹⁰*Id.* This standard fails to heed the explanation of EMTALA's purposes in *Baber*, also from the Fourth Circuit, in which the court stated that the Act was not concerned with a physician's medical judgment. See *Baber*, 977 F.2d at 880.

⁹¹See *Power*, 42 F.3d at 858. At the same time, the court stated, we "wholeheartedly agree with the district court's view that there are 'sharp differences between a medical malpractice action and an EMTALA action.'" *Id.* at 864. Courts interpreting the Fourth Circuit's decisions have stated that "the Act does not impose a minimum standard of care, but rather only obligates the hospital to provide uniform care to all patients." *Bohannon v. Durham County Hosp. Corp.*, 24 F. Supp. 2d 527, 530 (M.D.N.C. 1998) (citing *Baber*, 977 F.2d at 879).

⁹²See *Vickers*, 78 F.3d at 144 ("disparate treatment of individuals perceived to have the same condition is the cornerstone of an EMTALA claim").

⁹³See *Correa*, 69 F.3d at 1193.

⁹⁴See *Williams*, 34 F.3d at 697; *C.M. v. Tomball Reg'l Hosp.*, 961 S.W.2d 236, 241 (Tex. App. 1997).

⁹⁵See *Vickers*, 78 F.3d at 143 (the "accuracy of the diagnosis is a question for state malpractice law, not EMTALA"); *Brooks*, 996 F.2d at 711; *Baber*, 977 F.2d at 879; *Gatewood*, 933 F.2d at 1039. "If disparate treatment based on disparate diagnosis sufficed to raise a claim under EMTALA, every allegation of misdiagnosis could automatically be recast as a claim under the Act." *Vickers*, 78 F.3d at 144.

⁹⁶See *Repp*, 43 F.3d at 522; *Baber*, 977 F.2d at 881 (a hospital "satisfies the requirements of Section 1395dd(a) if its standard screening procedure is applied uniformly to all patients in similar medical circumstances"); *Gatewood*, 933 F.2d at 1041 (hospital satisfies screening requirement when particular screening conforms to its standard screening procedures). But see *Baber*, 977 F.2d at 879 n.7 (Our holding, however, does not foreclose the possibility that a

determines the presence and nature of an emergency medical condition.⁹⁷ But even non-uniformity does not violate EMTALA if the variations are minor. Thus, in cases where the hospital allegedly failed to screen properly, courts have found an exception for "*de minimis*" variations from a hospital's standard screening policy.⁹⁸ Furthermore, while hospitals may have general screening procedures, they may also tailor them to the particular patient's symptoms.⁹⁹ Finally, there is no violation of EMTALA's screening requirement under any of the three approaches if the hospital fails to ask screening questions where the patient's answers would be obvious or where the information sought is available from another source.¹⁰⁰ This is in accordance with the spirit of the Act, as courts should not discourage through EMTALA liability the expedience of a hospital's staff.

Stabilization and Transfer Standards

A hospital's duty to stabilize arises only if an individual has an emergency medical condition. EMTALA defines an emergency medical condition as:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.¹⁰¹

future court faced with such a situation [*i.e.*, ineffective screening] may decide that the hospital's standard was so low that it amounted to no "appropriate medical screening."); *C.M.*, 961 S.W.2d at 241.

⁹⁷See *Repp*, 43 F.3d at 522 n.4 (A court should only ask whether the hospital adhered to its own procedures, not whether the procedures were adequate if followed).

⁹⁸See *id.* at 523 (holding that minor variations from the hospital's standard screening policy do not constitute an EMTALA violation).

⁹⁹See *Baber*, 977 F.2d at 879 n.6.

¹⁰⁰See *Repp*, 43 F.3d at 523 (noting that although nurses did not ask specific questions about history and pre-existing conditions, they obtained the necessary information).

¹⁰¹*Camp v. Harris Methodist Fort Worth Hosp.*, 983 S.W.2d 876, 880 (Tex. Ct. App. 1998) (paraphrasing 42 U.S.C. § 1395dd(e)(1)).

A woman in labor is deemed to have an emergency medical condition.¹⁰² In essence, "an emergency medical condition exists only if a patient is in 'imminent' danger of death or a worsening condition that could be life threatening,"¹⁰³ or is in excruciating pain.¹⁰⁴

Interestingly, one court concluded from the text of the transfer provision that hospitals had a duty to stabilize emergency medical conditions about which it had no knowledge, and even conditions about which it *could not possibly have knowledge*.¹⁰⁵ Read in isolation from the stabilization provision,¹⁰⁶ the transfer provision supports this expansive interpretation.¹⁰⁷ This exceedingly strict liability is hardly the most faithful reading of the text, as the text of the stabilization provision (which is to be read in conjunction with the other provisions) only requires stabilization when "the hospital determines that the individual has an emergency medical condition..."¹⁰⁸ Furthermore, strict liability for transfers of patients is not in accordance with

¹⁰²See 42 U.S.C. § 1395dd(e)(1)(B); *Hongsathavij v. Queen of Angels/Hollywood Presbyterian Med. Ctr.*, 73 Cal. Rptr.2d 695, 705 (Cal. Ct. App. 1998).

¹⁰³*Tolton v. American Biotyne, Inc.*, 854 F. Supp. 505, 511 (N.D. Ohio 1993), *aff'd*, 48 F.3d 937 (6th Cir. 1995); *Camp*, 983 S.W.2d at 880; *Watts v. Hermann Hosp.*, 962 S.W.2d 102, 104 (Tex. Ct. App. 1997).

¹⁰⁴See 42 U.S.C. § 1395dd(e)(1)(A) (1994).

¹⁰⁵See *Carodenuto v. New York City Health & Hosp. Corp.*, 593 N.Y.S.2d 442, 446 (N.Y. Sup. Ct. 1992).

¹⁰⁶It is to avoid situations like this that the courts have created a rule of construction requiring that one section of a statute is to be read in conjunction with the other sections of that statute. See *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 94-95 (1993) (stating that the Court's examination of statutory language is "guided not by a single sentence or member of sentences, but look[s] to the provisions of the whole law, and to its object and policy" (internal quotations omitted)); *Conroy v. Aniskoff*, 507 U.S. 511, 515 (1993) ("A statute is to be read as a whole...").

¹⁰⁷The section of EMTALA dealing with transfers, unlike the stabilization section, has no knowledge requirement. See 42 U.S.C. § 1395dd(c). Therefore, under a literal reading of the transfer section, a hospital may not transfer a patient (which includes discharging a patient) without stabilizing his emergency medical condition, unless one of the exceptions applies, none of which addresses a hospital's lack of knowledge about the condition. Thus, a reading of this section that fails to incorporate the knowledge requirement of the stabilization section "leads inescapably to the conclusion that stabilization is required if the patient 'has an emergency medical condition' even if that condition is not diagnosed." *Carodenuto*, 593 N.Y.S.2d at 446.

¹⁰⁸See 42 U.S.C. § 1395dd(b)(1) (1994).

EMTALA's purposes,¹⁰⁹ as it regulates medical mistakes rather than patient-dumping.¹¹⁰

Wisely, most courts have rejected this approach and instead have held that EMTALA's duty to stabilize does not arise unless the hospital first knows that the patient is suffering from an emergency medical condition.¹¹¹ Thus, because of this actual knowledge limitation, the stabilization provision is unlike EMTALA's screening provision. The stabilization provision does not impose strict liability.¹¹² Liability for failing to stabilize, whether the patient is eventually transferred or not, will only attach where the examining physician had actual knowledge of the patient's emergency condition.¹¹³ "The Act does not hold hospitals accountable for failing to stabilize conditions of which they are not aware, or even emergency conditions of which they should have been aware."¹¹⁴

The fact that a hospital was merely suspicious that a patient had an emergency medical condition does not cause EMTALA's duty to stabilize to attach.¹¹⁵ Moreover, knowledge of a medical condition is

¹⁰⁹See Singer, *supra* note 17, at 167 (the *Carodento* "holding and its implications are directly contrary to the legislative history of the Act").

¹¹⁰This interpretation does serve EMTALA's purposes insofar as it encourages vigilance in assessing a patient's medical condition. This increased vigilance should result in the discharge of fewer patients (both indigent and insured) without proper treatment. It should also prevent dumping by those hospitals that feign ignorance of the patient's emergency condition. The problem with this interpretation is its overbreadth.

¹¹¹42 U.S.C. § 1395dd(b)(1) (1994); see *Camp*, 983 S.W.2d at 830.

¹¹²See *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999) (EMTALA is not a strict liability statute).

¹¹³See 42 U.S.C. § 1395dd(b)(1) & (c) (1994) ("If...the hospital determines that the individual has an emergency medical condition..."); *Marshall*, 134 F.3d at 324-25; *Summers v. Baptist Med. Ctr. of Arkadelphia*, 91 F.3d 1132, 1140 (5th Cir. 1996) (*en banc*) ("hospital must have actual knowledge"); *Eberhardt*, 62 F.3d at 1259 (no obligation to stabilize without knowledge of emergency medical condition); *Urban*, 43 F.3d at 525; *Holcomb*, 30 F.3d at 117; *Baber*, 977 F.2d at 883; *Gatewood*, 933 F.2d at 1041; *Cleland*, 917 F.2d at 268-69. Without an actual knowledge requirement, EMTALA essentially becomes a federal malpractice statute. *Urban*, 43 F.3d at 525.

¹¹⁴*Vickers*, 78 F.3d at 145; see *Barris*, 972 P.2d at 972 (EMTALA imposes liability for failure to stabilize a patient only if an emergency medical condition is actually discovered, rather than for negligent failure to discover and treat such a condition); *Stokes v. Candler Hosp., Inc.*, 453 S.E.2d 502, 505 (Ga. Ct. App. 1995) (the failure to diagnose a congenital defect did not constitute a failure to stabilize under EMTALA).

¹¹⁵See *Camp*, 983 S.W.2d at 830; *Casey v. Amarillo Hosp. Dist.*, 947 S.W.2d 301, 304 (Tex. App. 1997) (hospital's suspicion of patient's emergency condition not sufficient; must show actual knowledge of examining physicians).

imputed to the hospital through its physicians, but not through its nursing staff.¹¹⁶ Although critics argue that this actual knowledge rule encourages hospitals to remain intentionally ignorant of a patient's condition,¹¹⁷ one court has suggested that the rule might be relaxed if it were shown that a physician operated in bad faith and deliberately remained ignorant of the patient's condition.¹¹⁸ Despite such criticisms of this standard, making hospitals liable for failing to treat conditions about which the physician had no knowledge would be unduly harsh and would serve no useful purpose. Instead, this practice would only result in overly-cautious hospitals ordering a battery of unnecessary tests, further delaying the treatment of the patient in question and other emergency patients. This delay would hardly serve EMTALA's primary objective of ensuring prompt emergency medical treatment for the indigent. Thus, the actual knowledge rule is clearly the best one.

Stabilization occurs when "no material deterioration of the condition is likely, within reasonable medical probability,"¹¹⁹ or for purposes of labor, when the mother has delivered the child and the placenta.¹²⁰ "The statutory definition of 'stabilize' requires a flexible standard of reasonableness that depends on the circumstances."¹²¹ Several Circuits have held that the stabilization provision is unlike the screening provision in that stabilization requires more than just uniform treatment of all patients. Rather, as the text of the statute states, a hospital must prevent the material deterioration of each patient's condition according to the capabilities of the particular hospital.¹²² "In

¹¹⁶See *Camp*, 983 S.W.2d at 881; *Casey*, 947 S.W.2d at 304-05.

¹¹⁷See *James v. Sunrise Hosp.*, 86 F.3d 885, 888 (9th Cir. 1996) (noting that a knowledge requirement might encourage hospitals to evade the statute by instructing their staffs to make no determination as to the patient's emergency condition); *Urban*, 43 F.3d at 526. But the threat of a lawsuit under EMTALA for failing to properly screen, not to mention a state malpractice lawsuit, should provide sufficient incentive to prevent instances of deliberate misdiagnosis.

¹¹⁸See *James*, 86 F.3d at 889.

¹¹⁹*Thornton*, 895 F.2d at 1134 (quoting 42 U.S.C. § 1395dd(e)(4)(B)); see also *Eberhardt*, 62 F.3d at 1259 n.3; *In re Baby K*, 16 F.3d 590, 596 (4th Cir. 1994) (holding that hospital must prevent material deterioration of patient's emergency condition); 42 C.F.R. § 489.24(b) (1998).

¹²⁰See 42 C.F.R. § 489.24(b) (1998).

¹²¹*Cherukuri*, 175 F.3d at 454.

¹²²See *In re Baby K*, 16 F.3d at 596; *Burditt*, 934 F.2d at 1369 (EMTALA requires "treatment that medical experts agree would prevent the threatening and severe consequences of" the patient's condition while she was in transit); see also *Deberry*, 741 F. Supp. at 1305

comparison with the question of the appropriateness of the examination, the Act leaves no doubt that the question of whether the patient's medical condition was stabilized should be judged from the perspective of professional standards rather than standards established by each hospital.¹²³ Thus, the extent of the hospital's duty to stabilize is patient-specific.¹²⁴ The Fourth Circuit has further suggested that stabilizing treatment must be provided even when it would violate the hospital's ethical principles or is contrary to its standard practices.¹²⁵ Recently, a lawsuit claiming a violation of EMTALA's stabilization provision was filed after a Louisiana hospital stood by its ethical principles and refused to perform an abortion.¹²⁶

Generally, a hospital that knows about a patient's emergency medical condition cannot discharge or transfer the patient before stabilizing him,¹²⁷ regardless of whether the patient is eventually treated in parts of the hospital other than the emergency room.¹²⁸ "Hospitals cannot circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then eventually discharging that patient."¹²⁹ But EMTALA does not mandate medical care for an infinite duration.¹³⁰ Furthermore, the Act does not require hospitals or physicians to cure all of the patient's ailments.¹³¹ Once a patient is stabilized, the hospital's duty under EMTALA is extinguished, unless and until the patient experiences another

("the definition of 'to stabilize' asks whether the medical treatment...was reasonable under the circumstances. This is obviously a factual inquiry ...").

¹²³2 BARRY R. FURROW ET AL., HEALTH LAW 79 (1995).

¹²⁴See *Cherukuri*, 175 F.3d at 449 (stabilization is "purely contextual or situational").

¹²⁵See *In re Baby K*, 16 F.3d at 596, 597.

¹²⁶See Joe Gyan, Jr., *Heart Patient Sues Hospital, State Officials for Denying Abortion*, BATON ROUGE ADVOCATE, Mar. 12, 1999, at 4-B.

¹²⁷See *Huffine v. Tomball Hosp. Auth.*, 979 S.W.2d 795, 802 (Tex. App. 1998).

¹²⁸See *Thornton*, 895 F.2d at 1134.

¹²⁹*Id.* at 1135.

¹³⁰See *Bryan*, 95 F.3d at 352 (after stabilizing patient and treating her for twenty days, hospital had no duty to resuscitate her under EMTALA).

¹³¹*Green v. Touro Infirmary*, 992 F.2d 537, 539 (5th Cir. 1993); *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991); *Torres Nieves v. Hospital Metropolitano*, 993 F. Supp. 2d 127, 133 (D.P.R. 1998); *Watts*, 962 S.W.2d at 108; *Clark*, 657 So. 2d at 747 ("EMTALA requires only that a hospital stabilize an individual's medical condition and not that it cure the patient.").

emergency condition while at the hospital.¹³² Thus, after a patient is stabilized, the hospital and physician's treatment of the patient is governed by state law, not EMTALA.¹³³

Sometimes it is impossible for a hospital to fully stabilize a patient before transferring the patient to obtain care not available at the transferring hospital.¹³⁴ In these situations, EMTALA permits transfers of unstabilized patients where a physician or other qualified medical person certifies in writing that the transfer is in the patient's best interests.¹³⁵ In order for the transfer of unstabilized patients to be appropriate, the transferring hospital must minimize the risks of transfer as best it can. The receiving hospital must have appropriate facilities to treat the patient and must have agreed to accept the patient, and the transferring hospital must send to the receiving hospital all medical records relating to the patient's emergency condition.¹³⁶ The proper procedure for transferring patients is fraught with pitfalls.¹³⁷ In one case, a plaintiff brought a suit because the doctor failed to follow EMTALA's requirement that he summarize on the transfer certificate that the medical benefits of the transfer outweighed the risks.¹³⁸ Recognizing that the purpose of this provision is simply to ensure that doctors consider the risks and benefits before transferring a patient, the Ninth Circuit permitted the doctor in question to show through extrinsic evidence that he truly weighed the appropriate factors before transferring the patient.¹³⁹ In another case, the Department of Health and Human Services brought an enforcement action against a doctor who allegedly commenced the transfer of emergency patients before receiving the express consent of the receiving hospital.¹⁴⁰ The doctor

¹³²See *Green*, 992 F.2d at 539; *Reynolds*, 861 F. Supp. at 223; *Clark*, 657 So. 2d at 747; *Stokes*, 453 S.E.2d at 505.

¹³³*Bryan*, 95 F.3d at 351.

¹³⁴*Kilcup v. Adventist Health, Inc.*, 57 F. Supp. 2d 925, 930 (N.D. Cal. 1999).

¹³⁵See 42 U.S.C. § 1395dd(c)(1)(A)(ii) & (iii) (1994).

¹³⁶See 42 U.S.C. § 1395dd(c)(2) (1994).

¹³⁷See 42 U.S.C. § 1395dd(c)(1) & (2) (1994); *supra* note 28.

¹³⁸See *Vargas*, 98 F.3d at 1203.

¹³⁹See *id.*, 98 F.3d at 1205; see also *Kilcup*, 57 F. Supp. 2d at 930 (Even if the certification is not in writing, a physician may satisfy the requirement by convincing evidence that the evaluation was made); *Romo v. Union Mem'l Hosp., Inc.*, 878 F. Supp. 837, 844 (W.D.N.C. 1995) (absence of summary does not necessarily result in EMTALA liability but creates jury question).

¹⁴⁰See *Cherukuri v. Shalala*, 175 F.3d 446, 448 (6th Cir. 1999).

was not ultimately fined in that case because the Sixth Circuit recognized that EMTALA's requirement that the transferring hospital obtain the consent of the receiving hospital only applies when the hospital transfers an unstabilized patient.¹⁴¹

The bottom line is that under the language of [42 U.S.C. §1395dd] subsections (b) and (c), including the definition of "stabilized" in subsection (e), a physician may transfer any emergency room patient to another hospital without any certifications and without the express consent of the receiving hospital if he reasonably believes that the transfer is not likely to cause a "material deterioration" of the patient's condition.¹⁴²

Thus, when a stabilized patient is being transferred, compliance with these provisions is not required.

Civil Enforcement of EMTALA

Administrative Enforcement

The federal government enforces EMTALA jointly through the Health Care Financing Administration (HCFA) and the Office of Inspector General (OIG) of the United States Department of Health and Human Services.¹⁴³ The statute provides for civil fines not to exceed \$50,000 per hospital (or \$25,000 where the hospital has less than 100 beds) for each violation.¹⁴⁴ Both hospitals and physicians are liable for financial penalties whether they intentionally or negligently violate EMTALA.¹⁴⁵ To date, over 700 hospitals have been subject to government enforcement actions.¹⁴⁶ In fiscal 1999, the OIG collected about \$1.7 million through sixty-one settlements or judgments.¹⁴⁷ Notably, fines

¹⁴¹See *id.*

¹⁴²*Id.* at 450.

¹⁴³Solicitation of Comments on the OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute, 63 Fed. Reg. 67,486, 67,486 (1998).

¹⁴⁴See 42 U.S.C. § 1395dd(d)(1)(A) (1994); *Luckey*, 496 S.E.2d at 540 n.2.

¹⁴⁵See *Inspector General v. Burditt*, No. C-42 (HHS July 28, 1989), *enforced*, 934 F.2d 1362 (5th Cir. 1991).

¹⁴⁶See ASPEN HEALTH LAW CENTER, EMERGENCY DEPARTMENT COMPLIANCE MANUAL 23 (Rusty McNew, ed.) (1998).

¹⁴⁷See Chad Bowman, *Federal Penalties for Patient Dumping Rise: Industry Wary of OIG's Broad Interpretation*, 68 BNA'S U.S. LAW WEEK 2275, 2275 (Nov. 16, 1999). In fiscal

imposed on physicians generally are not covered under professional malpractice insurance policies, which greatly increases their deterrent effect.¹⁴⁸ EMTALA also mandates a stiffer penalty for flagrant or repeated violations. In such cases, EMTALA provides for exclusion of hospitals and physicians from the Medicare program.¹⁴⁹ Of course, this exclusion can be devastating, as one author has noted:

Most authorities feel that the real economic weapon of this legislation is not the \$50,000 fine but, rather, the "fast track termination" from Medicare. The public image of the hospital is likely to be significantly damaged when announcements in local newspapers read that "the hospital is in an immediate and serious threat to patient care and will be terminated from Medicare."¹⁵⁰

An abbreviated outline of the administrative procedure may be helpful.¹⁵¹ The government enforcement process is started when a complaint is made to HCFA or the OIG, or to a state agency that is required to transmit the complaint to HCFA.¹⁵² State agencies will initially investigate the matter and report their findings to HCFA.¹⁵³ If, based on the state report, HCFA determines that a violation of EMTALA has occurred, it will inform the offending hospital. If the violation is considered serious (and this is a purely subjective determination), HCFA can initiate "fast track" termination of participation in the Medicare program.¹⁵⁴ This will result in termination approximately twenty-three days after the hospital is informed by HCFA.¹⁵⁵ If the violation is not considered serious, a process that could result in termination within ninety days is initiated

1998 the OIG netted about \$1.8 in fifty-four cases. See Eric Weissenstein, *HHS 1998 Fraud Collections Drop*, MODERN HEALTHCARE, Dec. 7, 1998, at 12.

¹⁴⁸See MIKEL A. ROTHENBERG, EMERGENCY MEDICINE MALPRACTICE § 1.11 (1994).

¹⁴⁹42 U.S.C. § 1395dd(d)(B) (1994).

¹⁵⁰ROTHENBERG, *supra* note 148, at § 1.11.

¹⁵¹See GREGORY M. LUCE, DEFENDING THE HOSPITAL UNDER EMTALA: NEW REQUIREMENTS/NEW LIABILITIES 4-13 (1995) (containing a more detailed discussion).

¹⁵²See 42 C.F.R. § 488.18(d) (1998).

¹⁵³See LUCE, *supra* note 151, at 4.

¹⁵⁴See 42 C.F.R. § 489.53(c)(2) (1998).

¹⁵⁵See *id.*

instead.¹⁵⁶ Whether HCFA pursues fast track or protracted termination, hospitals can still prevent termination by implementing changes that bring them into compliance. If the hospital does not achieve compliance, it will be terminated. When a physician is going to be excluded or civil penalties assessed against physicians or hospitals, the Secretary *must* request a report from the appropriate peer review organizations concerning whether a violation occurred.¹⁵⁷

Regardless of whether termination from Medicare is pursued, the OIG can pursue civil penalties. If the OIG and the offending hospital cannot reach a settlement, the OIG must prove to an administrative law judge (ALJ) by a preponderance of the evidence that a violation of EMTALA has occurred.¹⁵⁸ As in most agency decisions, the ALJ's tend to side with the Inspector General and make credibility determinations accordingly.¹⁵⁹ The ALJ's decision is appealable to an administrative appeals board.¹⁶⁰ Unfortunately, the review by the administrative board is sometimes cursory.¹⁶¹ Adverse decisions are then appealable to the United States Courts of Appeals, which have broad power to review the ALJ's interpretations of the statute but which may perform only a limited review of the ALJ's factual findings under the substantial evidence standard.¹⁶²

¹⁵⁶See LUCE, *supra* note 151, at 5.

¹⁵⁷See 42 C.F.R. § 489.24(g) (1998); WAXMAN, *supra* note 61, at 13; LUCE, *supra* note 151, at 4.

¹⁵⁸See WAXMAN, *supra* note 61, at 12.

¹⁵⁹See *Inspector General v. Cherukuri*, No. C-96-020 (HHS May 23, 1997), *not enforced*, 175 F.3d 446 (6th Cir. 1999).

¹⁶⁰See *Cherukuri*, 175 F.3d at 448-49.

¹⁶¹See *id.* at 455. This lack of substantial review led the Sixth Circuit to criticize the Board:

It is unfortunate that the errors we have uncovered were not caught earlier in the administrative process. When the administrative "Review Board" established to administer EMTALA cases chooses without explanation to make an ALJ decision in an important case binding without review, the burden on the Court of Appeals to comb the record is substantially increased. We respectfully suggest that the Board should review cases like this one closely and should not simply pass them on to a federal appellate court without providing a reasoned disposition of the objections raised by the parties.

Id.

¹⁶²See *id.* at 449 n.1; 42 U.S.C. § 1320a-7a(e) (1994). "Substantial evidence" means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.

In one of the first cases brought by the Inspector General for patient dumping, a physician was fined \$20,000 for refusing to treat a woman in labor who also had high blood pressure. When called to treat her, Dr. Burditt told the nurses that he "didn't want to take care of this lady," and ordered her to be taken to a hospital 170 miles away.¹⁶³ Fortunately, neither the woman nor her child suffered any serious ill effects from the ordeal.¹⁶⁴ In another case, the Sixth Circuit refused to enforce a \$100,000 fine against a physician who transferred two trauma patients to a hospital better-equipped to deal with severe head injuries.¹⁶⁵ It found that the administrative law judge misinterpreted the meaning of "stabilize" and that there was not substantial evidence to support a finding that the patients were not stabilized before transfer.¹⁶⁶ It also held that a physician could not be liable for failing to perform surgery that might have stabilized the patient's medical condition when an anesthesiologist refused to provide anesthesia for the surgery, despite the ALJ's finding that the physician should have forced the anesthesiologist to assist him.¹⁶⁷

Private Lawsuits

EMTALA also provides for private lawsuits by patients claiming violations of the statute.¹⁶⁸ The Act provides:

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.¹⁶⁹

See *Richardson v. Perales*, 402 U.S. 389, 401 (1971). In a substantial evidence determination, the court of appeals reviews the entire record; however, it does not substitute its judgment for that of the Board by reconsidering facts, re-weighting evidence, resolving conflicts in evidence, or deciding questions of credibility. See *Estok v. Apfel*, 152 F.3d 636, 638 (7th Cir. 1998).

¹⁶³See *Burditt*, 934 F.2d at 1366, 1366.

¹⁶⁴See *id.*

¹⁶⁵See *Cherukuri*, 175 F.3d at 446.

¹⁶⁶See *id.* at 455.

¹⁶⁷See *id.* at 452.

¹⁶⁸See 42 U.S.C. § 1395dd(d)(2)(A) (1994).

¹⁶⁹*Id.*

Although the government can pursue monetary penalties against hospitals and physicians,¹⁷⁰ under the terms of the statute, plaintiffs can only sue the hospital, and not the physician or health care workers.¹⁷¹ The two most common claims brought under EMTALA are failure to screen adequately and failure to stabilize an emergency medical condition, which includes failure to stabilize before transferring the individual.¹⁷² These are two separate claims, so a plaintiff alleging failure to stabilize need not allege or prove that the hospital did not provide an adequate screening, and vice versa.¹⁷³

An EMTALA lawsuit may be initiated in either state or federal court.¹⁷⁴ Recovery is limited by the statute's own terms to "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of [this section]..."¹⁷⁵ Courts have struggled with the question of who is an "individual" capable of suing under EMTALA,¹⁷⁶ as this term could conceivably refer to members of the patient's family who suffered emotional harm caused by a violation of EMTALA.¹⁷⁷ But the rules of statutory construction indicate that the term "individual" as the term is used in subsection (d), has the same meaning as in other subsections.¹⁷⁸ In the other

¹⁷⁰See *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 877 (4th Cir. 1992).

¹⁷¹See *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1256 (9th Cir. 1995); *King v. Ahrens*, 16 F.3d 265, 271 (8th Cir. 1994); *Delaney v. Cade*, 986 F.2d 387, 393-94 (10th Cir. 1993); *Baber*, 977 F.2d at 877-78; *Gatewood*, 933 F.2d at 1040 n.1. There is no basis to imply a private cause of action against the physician either. See *King*, 16 F.3d at 271.

¹⁷²Although uncommon, a plaintiff could conceivably make a claim for failure to transfer him when requested, failure to accept a transferred patient, and delay in screening, stabilizing or transferring. As the statute states, a civil action may be brought for any harm caused by any "violation of a requirement of this section." 42 U.S.C. § 1395dd(d)(2)(A) (1994).

¹⁷³See *Urban*, 43 F.3d at 526 (a plaintiff "need not show a violation of Section 1395dd(a), emergency room screening requirement, to succeed in an action brought under Section 1395dd(c)").

¹⁷⁴See, e.g., *Huffine v. Tomball Hosp. Auth.*, 979 S.W.2d 795 (Tex. App. 1998); *Trivette v. North Carolina Baptist Hosp., Inc.*, 507 S.E.2d 48 (N.C. Ct. App. 1998); *Lear v. Genesee Mem'l Hosp.*, 678 N.Y.S.2d 228 (N.Y. App. Div. 1998).

¹⁷⁵42 U.S.C. § 1395dd(d)(2)(A)) (1999).

¹⁷⁶See *Zeigler v. Elmore County Health Care Auth.*, 56 F. Supp. 2d 1324, 1326 (M.D. Ala. 1999).

¹⁷⁷See *Kilcup*, 57 F. Supp. 2d at 932 (Kilcup's adult children alleged that they suffered personal harm as a result of defendant's violation of EMTALA).

¹⁷⁸See *In re Davis*, 170 F.3d 475, 480 (5th Cir. 1999) (en banc) ("An interpretation that gives the same words in the same Act a different meaning 'flatly contradicts standard canons of statutory interpretation, for the same language in a single statutory provision cannot have two different meanings.'") (quoting *Sullivan v. Stroop*, 496 U.S. 478, 484 (1990)); *Halicki v.*

subsections, it is clear that "individual" means the "individual ...[who] comes to the emergency department..." seeking a medical screening,¹⁷⁹ or "any individual [who] has an emergency medical condition..." and seeks treatment.¹⁸⁰ This term does not encompass the patient's family.¹⁸¹ Thus, only the patient denied a screening or stabilizing treatment could recover under EMTALA. Accordingly, one court has held that a mother could not sue under EMTALA in her individual capacity for harm done to her infant daughter.¹⁸² But other courts have effectively disregarded the "personal harm as a direct result" language or minimized it such that EMTALA exceeds its scope.¹⁸³ For example, one court held that a hospital's delay in treating an infant prolonged her suffering to some extent, and this was considered to be sufficient harm to sue under EMTALA.¹⁸⁴ Some courts have gone even farther afield. One such court allowed the mother of a patient denied an appropriate screening and treatment to sue for the mental anguish and lost wages she suffered.¹⁸⁵ Another court held that EMTALA does not preclude the recovery of damages for loss of familial support and the like.¹⁸⁶ Of course, survivor actions are permissible under the Act to the extent that state law allows them,¹⁸⁷ as these actions are suits brought on the

Louisiana Casino Cruises, Inc., 151 F.3d 465, 469 (5th Cir. 1998) ("There is a 'basic canon of statutory construction that identical terms within an Act bear the same meaning.'" (quoting *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 479 (1992))).

¹⁷⁹See 42 U.S.C. § 1395dd(a) (1994).

¹⁸⁰See *id.* at (b)(1).

¹⁸¹See *Zeigler*, 56 F. Supp. 2d at 1326. The *Zeigler* court used legislative history to support this conclusion. "The legislative history thus suggests quite strongly that Congress intended to allow suit only by what the House Judiciary Committee called the 'individual patient,' that is, the individual for whose medical condition the emergency medical examination or treatment was sought." *Id.* The rules of statutory construction, however, lead to the same result without resorting to legislative history.

¹⁸²See *Zeigler*, 56 F. Supp. 2d at 1327.

¹⁸³See, e.g., *C.M.*, 961 S.W.2d at 242.

¹⁸⁴See *Zeigler*, 56 F. Supp. 2d at 1327.

¹⁸⁵See *id.*

¹⁸⁶See *Correa*, 69 F.3d at 1196 (construing 42 U.S.C. § 1395dd(d)(2)).

¹⁸⁷See *id.*; *Jackson v. East Bay Hosp.*, 980 F. Supp. 1341, 1354 (N.D. Cal. 1997); *Lane v. Calhoun-Liberty County Hosp. Ass'n, Inc.*, 846 F. Supp. 1543, 1552-53 (N.D. Fla. 1994); *Griffith*, 826 F. Supp. at 383-84. Despite discussing survivor actions, the First Circuit in *Correa* seemed to say that wrongful death actions would also be permitted under EMTALA. It stated: "It is equally open to read the law as permitting an individual who has a special relationship with another – say a wife deprived consortium or, as here, a bereaved relative – to sue when she is harmed in direct consequence of an EMTALA violation inflicted upon such other." *Correa*, 69 F.3d at 1196.

decendent's behalf to compensate him for personal harm he suffered before his death.¹⁸⁸ "The survival action, as it is called, is not a new cause of action. It is rather the cause of action held by the decedent immediately before or at death, now transferred to his personal representative."¹⁸⁹ Survival actions should be contrasted with wrongful death actions, which should not be permitted under the Act to the extent they are based not on the harm done to the patient, but on the loss suffered by the family as a result of his death.¹⁹⁰ The Act's "individual" and "personal harm" caveats also limit the courts' ability to grant equitable relief,¹⁹¹ so that an injunction can only require a hospital to treat the particular plaintiffs seeking the injunction.¹⁹²

Unlike many other federal remedial statutes, there is no administrative procedure that must first be exhausted, such as filing a complaint with the HCFA.¹⁹³ There is, however, a two-year statute of limitations.¹⁹⁴ This provision is strictly construed and is not tolled for incompetency, infancy, disability,¹⁹⁵ or state procedural grounds.¹⁹⁶ EMTALA does not preempt any pendant state law claims that a plaintiff might initiate,¹⁹⁷ including claims under comparable state statutes.¹⁹⁸ Thus plaintiffs frequently bring an EMTALA claim along

¹⁸⁸See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 126, at 942 (5th ed. 1984).

¹⁸⁹*Id.*

¹⁹⁰See *Holmes v. Acands, Inc.*, 709 N.E.2d 36, 41 n.2 (Ind. Ct. App. 1999) ("A wrongful death action is not for the benefit of the decedent, but on behalf of the decedent's survivors."); *City of Pompano Beach v. T.H.E. Ins. Co.*, 709 So. 2d 603, 605 (Fla. Dist. Ct. App. 1993) (Wrongful death actions "are brought on behalf of the survivors, not to recover for injuries to the deceased..."). "All American Jurisdictions except Hawaii and Massachusetts have required statutory authority for a wrongful death recovery." *Powell v. American Motors Corp.*, 334 S.W.2d 184, 186 (Mo. 1992).

¹⁹¹See 42 U.S.C. § 1395dd(d)(2)(A) (1999).

¹⁹²See *Hart v. Riverside Hosp., Inc.*, 899 F. Supp. 264, 268 (E.D. Va. 1995).

¹⁹³See *Power*, 42 F.3d at 867.

¹⁹⁴See 42 U.S.C. § 1395dd(d)(2)(C) (1999).

¹⁹⁵See *Vogel v. Linde*, 23 F.3d 78, 80 (4th Cir. 1994).

¹⁹⁶See *Burrows v. Turner Mem'l Hosp., Inc.*, 762 F. Supp. 840, 843 (W.D. Ark. 1991) (state law which tolls the statute of limitations for one year upon voluntary dismissal of lawsuit does not toll EMTALA's two-year statute of limitations).

¹⁹⁷See *Casey v. Amarillo Hosp. Dist.*, 947 S.W.2d 301, 304 (Tex. App. 1997).

¹⁹⁸See, e.g., LA. REV. STAT. ANN. § 40:2113.4 (1998).

with numerous state law claims.¹⁹⁹ EMTALA also does not preempt state notice-of-claim laws, as long as these provisions do not directly conflict with EMTALA's purposes.²⁰⁰ Based on this limitation, the Virginia Supreme Court and the Fourth Circuit found that Virginia's notice-of-claim statute, which entailed administrative limitations beyond merely giving notice, was preempted by the Act.²⁰¹ Similarly, a court held that an Indiana law that required the filing of the proposed complaint with the Indiana Department of Insurance medical review panel directly conflicted with and was preempted by EMTALA.²⁰²

State law also governs the availability of damages and equitable relief under EMTALA.²⁰³ This includes state caps on damage awards.²⁰⁴ In making these limitations applicable to EMTALA claims, "the apparent intent of Congress was to balance the deterrence and compensatory goals of EMTALA with deference to the ability of states to determine what limits are appropriate in personal injury actions against health care providers."²⁰⁵ Thus, one court held that Maine's wrongful death cap of \$150,000 was applicable to an EMTALA claim.²⁰⁶ Of course, EMTALA also "incorporates all the vagaries of the state medical malpractice law in the determination of the damages recoverable in an action under the Act."²⁰⁷ Accordingly, some courts have held that state laws limiting damage awards for medical malpractice apply to EMTALA,²⁰⁸ while others have refused to so

¹⁹⁹See, e.g., *Feighery v. York Hosp.*, 38 F. Supp. 2d 142, 145 (D. Me. 1999) (complaint alleged claims for violations of EMTALA, wrongful death, negligent infliction of emotional distress, and medical malpractice).

²⁰⁰See *Hardy v. New York City Health & Hosp. Corp.*, 164 F.3d 789, 794 (2d Cir. 1999); *Draper v. Chiapuzio*, 9 F.3d 1391, 1394 (9th Cir. 1993).

²⁰¹See *Power*, 42 F.3d at 866; *Smith*, 416 S.E.2d at 695.

²⁰²See *HCA Health Servs. of Ind., Inc. v. Gregory*, 596 N.E.2d 974, 977 (Ind. Ct. App. 1992) (Indiana law which required the filing of the proposed complaint with the Indiana Department of Insurance medical review panel directly conflicted with and was preempted by EMTALA).

²⁰³See 42 U.S.C. § 1395dd(d)(2)(A) ("Any individual who suffers personal harm as a direct result of a participating hospital, obtains those damages available for personal injury under the law of the state in which the hospital is located, and such equitable relief as is appropriate").

²⁰⁴See *Barris*, 972 P.2d at 976.

²⁰⁵*Id.* at 973.

²⁰⁶See *Feighery*, 38 F. Supp. 2d at 158.

²⁰⁷*Diaz v. CCHC-Golden Glades, Ltd.*, 696 So. 2d 1346, 1347 (Fla. Dist. Ct. App. 1997).

²⁰⁸See *Power*, 42 F.3d at 861 (Virginia's \$1 million cap on malpractice awards applies to EMTALA); *Lee*, 778 F. Supp. at 903-04 (Indiana's limitation on malpractice recoveries applies

hold.²⁰⁹ But even these latter courts have said that state law limitations will apply to EMTALA cases in which the plaintiff is "unable to show anything more than a case of negligent medical malpractice."²¹⁰ Similarly, the California Supreme Court held California's medical injury cap of \$250,000 for non-economic losses was applicable to an EMTALA failure to stabilize claim because if the claim were brought under state law, the cap would have been applied.²¹¹ Addressing a slightly different issue, the Wisconsin Supreme Court recently held that because EMTALA claims so closely resemble medical malpractice claims, the Wisconsin Patients Compensation Fund (designed to provide coverage for medical malpractice claims) provides excess coverage for violations of EMTALA.²¹² Because of EMTALA's incorporation of state law, the plaintiff's ability to recover under the statute will expand and contract depending on the jurisdiction where the hospital is located. Accordingly, if the particular state law permits, plaintiffs may recover for their pain, suffering, and humiliation.²¹³ For example, in a case where the hospital failed to follow its standard procedures in providing a medical screening of a young rape victim, the court indicated that the patient might recover damages for lost wages, mental anguish, pain and suffering, and reasonable attorneys' fees.²¹⁴ State law also controls the question of whether punitive damages are available in an EMTALA action.²¹⁵

Because courts differ on whether medical negligence results in EMTALA liability, it is not surprising that one state court that analogized an EMTALA claim to a malpractice claim applied comparative fault principles.²¹⁶ Another court refused to apply the

to EMTALA claims); *Reid v. Indianapolis Osteopathic Med. Hosp., Inc.*, 709 F. Supp. 352, 355 (S.D. Ind. 1989) (Virginia's cap).

²⁰⁹See *Cooper v. Gulf Breeze Hosp., Inc.*, 839 F. Supp. 1538, 1543 (N.D. Fla. 1993); *Spradlin v. Acadia-St. Landry's Med. Found.*, 711 So. 2d 699, 702-03 (La. Ct. App. 1998).

²¹⁰See *Spradlin*, 711 So. 2d at 702 n.5.

²¹¹See *Barris*, 972 P.2d at 974, 976.

²¹²See *Burks v. St. Joseph's Hosp.*, 596 N.W.2d 391, 402 (Wisc. 1999).

²¹³See *C.M.*, 961 S.W.2d at 242.

²¹⁴See *id.*

²¹⁵See *Taylor v. Dallas County Hosp. Dist.*, 976 F. Supp. 437, 438 (N.D. Tex. 1996) (denying punitive damages based on state law); *Griffith*, 826 F. Supp. at 385 (denying punitive damages based on Kansas law which precludes punitive damages in wrongful death cases).

²¹⁶See *Clark v. Baton Rouge Gen. Med. Ctr.*, 657 So. 2d 741, 748-49 (La. Ct. App. 1995).

doctrine, reasoning that proof of medical negligence was irrelevant to EMTALA.²¹⁷ State tort law concerning intervening agency or superseding causes also applies to EMTALA claims.²¹⁸ For example, in one case the patient failed to heed the hospital's instruction to see his family physician.²¹⁹ In this failure to properly screen case, the court ruled that this failure was a superseding cause of the patient's heart attack that occurred three weeks after his screening at the hospital, thereby precluding liability under EMTALA for failing to properly screen.²²⁰ Finally as to state hospitals and Eleventh Amendment Immunity, some courts have correctly held that Congress has not abrogated this immunity from lawsuits in federal court,²²¹ while others have taken the opposite view.²²² As to the federal government's immunity from suits, one court has held that Congress did not waive this immunity in enacting EMTALA.²²³

THE ROBERTS CASE

The Facts

In May 1992, Wanda Johnson was brought to the emergency room at Humana Hospital-University of Louisville in Kentucky, after suffering severe injuries caused by a collision with a truck.²²⁴ She did not complain about the care she received, and the Hospital seems to have

²¹⁷See *Griffith*, 842 F. Supp. at 1365 (comparative fault is not applicable because a plaintiff is not required to prove negligence in order to recover under EMTALA).

²¹⁸See *Tolton v. American Biotyne, Inc.*, 48 F.3d 937, 944 (6th Cir. 1995); *Williams*, 34 F.3d at 697.

²¹⁹See *Williams*, 34 F.3d at 696.

²²⁰See *id.* at 697.

²²¹See *Ward v. Presbyterian Healthcare Servs.*, 72 F. Supp. 2d 1285, 1290 (D. N.M. 1999); *Lebron v. Ashford Presbyterian Community Hosp.*, 975 F. Supp. 407, 409 (D.P.R. 1997); *Isidra v. Perez-Bourdon v. Commonwealth of Puerto Rico*, 951 F. Supp. 22, 24 (D.P.R. 1997).

²²²See *Williams v. County of Cook*, No. 97-C-1069, 1997 WL 428534, at *5 (N.D. Ill. 1997) (EMTALA preempts Illinois Tort Immunity Act); *Etter v. Board of Trustees of N. Kansas City Hosp.*, No. 95-0624-CV-W-6, 1995 WL 634472, at *2 (W.D. Mo. 1995); *Helton v. Phelps County Reg'l Med. Ctr.*, 817 F. Supp. 789, 791 (E.D. Mo. 1993) (EMTALA preempts Missouri statute "which provides sovereign immunity to public entities to the extent they have no insurance coverage").

²²³See *Cheromiah v. United States*, 55 F. Supp. 2d 1295, 1300 (D.N.M. 1999).

²²⁴See *Roberts v. Galen of Virginia, Inc.*, 111 F.3d 405, 406-07 (6th Cir. 1997), *rev'd*, 119 S. Ct. 685 (1999).

fulfilled its duties in treating her injuries. However, in July of 1992, a surgical resident suggested to a social worker that she find a long-term nursing facility for Johnson.²²⁵ The resident was unaware that Johnson did not have insurance to cover payment for Humana's treatment.²²⁶ It appeared that the resident's intentions were innocent in that he was not motivated by a desire to deny treatment to an indigent patient. After being rejected by two facilities, the Crestview Health Care Facility agreed to admit Johnson, and she was transferred there on July 24, 1992.²²⁷ Johnson's condition immediately deteriorated, and the next day she was admitted to the Midwest Medical Center in Indiana, where she was treated for many months.²²⁸ This extensive care required cost almost \$400,000.²²⁹ Because she failed to meet Indiana's residency requirements, Johnson was not eligible for financial assistance under Medicaid.²³⁰

In 1993, Johnson's guardian, Jane Roberts, filed a lawsuit under EMTALA, alleging Humana failed to stabilize Johnson before transferring her to Crestview.²³¹ Humana moved for summary judgment, arguing there was no genuine issue of material fact concerning whether Johnson's medical condition was stable at the time of her transfer to Crestview, or whether Humana had transferred her based on an improper motive.²³²

The Reasoning of the Court of Appeals

In addressing the *Roberts* case, the Sixth Circuit looked to its opinion in *Cleland v. Bronson Health Care Group, Inc.*²³³ *Cleland* involved both a failure to screen and failure to stabilize claim. The hospital misdiagnosed Cleland's illness as influenza and then discharged him.

²²⁵See *id.* at 407.

²²⁶See *id.*

²²⁷See *id.*

²²⁸See *id.*

²²⁹See *Roberts*, 111 F.3d at 407.

²³⁰See *id.*; see also IND. CODE § 12-15-4-4 (1998) (stating eligibility requirements for Medicaid).

²³¹See *Roberts*, 111 F.3d at 407. Roberts also alleged negligence under state law and violations of the Due Process and Equal Protection Clauses of the United States and Kentucky Constitutions. The district court granted summary judgment on these claims, and Roberts only appealed the EMTALA and negligence claims. See *id.*

²³²See *id.*

²³³See *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990).

Less than twenty-four hours later, Cleland suffered cardiac arrest and died. The Sixth Circuit sought to define the term "appropriate," as in the "appropriate medical screening examination" required by EMTALA.

The plaintiff in *Cleland* argued the term "appropriate," imposed a statutory obligation to provide an examination that did not violate state malpractice law and which rendered a correct diagnosis.²³⁴ In interpreting this term, the court looked to the legislative purpose of the statute: the prevention of the dumping of indigent patients. Because Congress was attempting to protect the indigent from dumping, the court reasoned that in mandating an "appropriate" screening examination, Congress was not concerned with minimal standards of screening or even a correct result.²³⁵ Thus, the court determined that the term "appropriate" must "be interpreted to refer to the motives with which the hospital acts."²³⁶ But then the court relied on a disparate treatment standard rather than an improper motive standard: "If it [the hospital] acts in the same manner as it would have for the usual paying patient, then the screening provided is 'appropriate' within the meaning of the statute."²³⁷ The court seems to have adopted a similar disparate treatment standard for the plaintiff's stabilization claim.²³⁸

[N]either the normal meaning of stabilization, nor any of the attendant legislative history or apparatus, indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge. In the hospital's opinion, the patient was stable, *and they would have believed that a patient with any differing characteristics would have been stable.*²³⁹

²³⁴See *id.* at 271.

²³⁵See *id.* ("Plaintiffs essentially contend [incorrectly] that 'appropriate' denotes, at a minimum, the full panoply of state malpractice law, and at a maximum, includes a guarantee of a successful result.").

²³⁶*Id.* at 272.

²³⁷*Id.*

²³⁸See *Cleland*, 917 F.2d at 271.

²³⁹*Id.* (emphasis added).

Finally, in announcing its reasons for affirming, the Cleland court specifically relied on the disparate treatment analysis, rather than the improper motive one.²⁴⁰

The *Roberts* court disregarded *Cleland's* disparate treatment analysis and instead seized upon the improper motive language. As it stated: "The District Court in the instant case properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA."²⁴¹ Also, it rejected "the position espoused by plaintiff that, to succeed on a claim under the EMTALA, she can prove that Humana's treatment of Johnson was not uniform to patients suffering from the same medical condition as Johnson."²⁴²

The *Roberts* court was concerned that some statutory interpretations would "effectively require a hospital, in defense of a claim under EMTALA, to either prove that it breached a standard of care to an individual patient or that it breaches the applicable standard of care with respect to all similarly situated patients." Striving to avoid this entanglement with state malpractice law, the court chose to adopt the motivation prerequisite: A plaintiff must show that the hospital employee responsible for the discharge were motivated by improper considerations, such as indigence, lack of insurance, race, sex, political affiliation, occupation, education, drunkenness, or spite.²⁴³ Furthermore, the plaintiff must show that his discharge from the hospital before being stabilized was caused by this motive.²⁴⁴ Because the plaintiff did not prove improper motive, the court affirmed the summary judgment for the hospital.²⁴⁵

²⁴⁰See *id.* at 268. In summarizing its decision, the court made no mention of an improper motive requirement: "we interpret the vague phrase 'appropriate medical screening' to mean a screening that the hospital would have offered to any paying patient..."

²⁴¹*Roberts*, 111 F.3d at 409.

²⁴²*Id.*

²⁴³*Id.*

²⁴⁴See *id.* at 411.

²⁴⁵Judge David Nelson, in dissent, had no quarrel with his colleagues rationale, only with their application of the motivation rule. He believed that the plaintiff had created a genuine issue of material fact as to whether the hospital acted with an improper motive. See *id.* at 413 (Nelson, J., dissenting).

The Supreme Court Addresses *Roberts*

By the time the *Roberts* case made its way to the Supreme Court, the Sixth Circuit was the only Circuit that had adopted the motivation requirement.²⁴⁶ Every other Circuit that addressed the question rejected this extra element as being an extra-textual judicial construction. Thus, it was not surprising that even the hospital's attorney conceded in its brief and at oral argument that there was no textual basis for the improper motive element. He stated:

[W]e do not defend the actual motive test adopted by the Sixth Circuit because it's reasonably clear to us that there is no basis in the text or the context of this particular statute to justify that particular analysis. And we do not think as hospitals that there are certainly certain situations where there are absolute obligations that are imposed upon us, for instance, in providing some form of a screening examination where an inquiry into the hospital's motive is simply not an appropriate inquiry, and on that basis alone, it's easy for us to set aside the actual motive test.²⁴⁷

Counsel for the hospital made a futile attempt to persuade the Court to affirm on other grounds.²⁴⁸ Forty-three days after oral argument, the Court reversed the Sixth Circuit in a *per curiam* opinion. In analyzing the Sixth Circuit's error, the Supreme Court recognized that the *Cleland* opinion first introduced the improper motivation test in an attempt to limit the scope of EMTALA, so that it did not become a federal malpractice statute.²⁴⁹ The court found that there was no textual basis for a motivation test.²⁵⁰ It held that Section 1395dd(b) contains no express or implied "improper motive requirement."²⁵¹ Because there was no failure to screen claim before it, the Court refused to make

²⁴⁶See A. Wade Norman, *EMTALA: U.S. Supreme Court Limits Improper Motive Doctrine in Patient Dumping Cases*, 27 J. L. MED. & ETHICS 99, 100 (1999).

²⁴⁷Transcript of Supreme Court Oral Argument, *Roberts v. Galen of Virginia, Inc.*, No. 97-53, Carter G. Phillips, Dec. 1, 1998, available at 1998 WL 846721, at *23.

²⁴⁸See *Roberts*, 119 S. Ct. at 687.

²⁴⁹See *id.* at 686. For commentary discussing the case see Thomas Heim, *EMTALA: Improper Motive Not Necessary: Roberts v. Galen of Virginia, Incorporated*, 25 AM. J.L. & MED 174 (1999).

²⁵⁰See *Roberts*, 119 S. Ct. at 667.

²⁵¹*Id.*

its holding applicable to those cases.²⁵² It did, however, note that no other Circuit adopted this test even for screening claims, and certainly implied that there is no basis for the test in any section of EMTALA.²⁵³ Despite the Supreme Court's suggestion that no part of EMTALA contains an improper motive requirement, the Sixth Circuit still requires plaintiffs alleging a failure to screen claim to show that the hospital acted with an improper motive.²⁵⁴

ANALYSIS

While the Supreme Court was undoubtedly correct in its "plain meaning" construction of EMTALA, the Sixth Circuit's interpretation of Congressional intent was consistent with evidence of that intent found in the Act's legislative history.²⁵⁵ It is universally recognized that the statute was designed to prevent the exclusion of patients because of their inability to pay for emergency medical care.²⁵⁶ Yet the effects of EMTALA are much greater than those envisioned by Congress.²⁵⁷ That is, while EMTALA was designed to curb the dumping of the indigent, by its own terms, it applies to "any individual" and not just its intended beneficiaries.²⁵⁸ As one court noted: While Congress may have intended to focus on the indigent and uninsured when it passed EMTALA, the language used was conducive to a much broader interpretation.²⁵⁹ Because of its overbreadth, the Act regulates hospitals' treatment of all patients, regardless of their economic status.²⁶⁰ Thus, even wealthy individuals who do not need

²⁵²See *id.*

²⁵³See *Roberts*, 119 S. Ct. at 687 n.1.

²⁵⁴See *Estate of Taylor v. Hall Regional Med. Ctr.*, No. 98-5052, 1999 WL 519295, at *2 (6th Cir. July 15, 1999) (*per curiam*).

²⁵⁵Regarding the dangers of using legislative history see *United States v. Public Util. Comm'n of Cal.*, 345 U.S. 295, 319 (1953) (Jackson, J., concurring) ("That process seems to me not interpretation of a statute but creation of a statute.").

²⁵⁶See *Pover*, 42 F.3d at 856 (EMTALA was designed to prevent patient dumping); *Gatewood*, 933 F.2d at 1041 (the "statute was designed principally to address the problem of 'patient dumping'").

²⁵⁷See *Singer*, *supra* note 17, at 121 (By inherently raising concepts of malpractice, COBRA's protections invite overuse by plaintiffs and misuse by the courts).

²⁵⁸See 42 U.S.C. § 1395dd(a).

²⁵⁹See *Burks v. St. Joseph's Hosp.*, 596 N.W.2d 391, 398 (Wisc. 1999).

²⁶⁰See *id.* (In recent years EMTALA has been construed to apply to all patients, irrespective of their ability to pay).

special protection can sue under EMTALA whenever a hospital fails to screen or treat them properly.

Admittedly, broad language is sometimes necessary in legislative drafting. But in this instance, EMTALA's overbreadth may ultimately produce effects that are at odds with the goals that Congress hoped to attain in enacting this statute.²⁶¹ The most obvious problem is with the variety of judicial interpretations (most of which enjoy some plausibility) caused by the vagueness and overbreadth of the statute. Thus, in attaching a motive requirement to the statute, the Sixth Circuit sought to limit the statute which, when left unrestrained, regulates emergency medical practices rather than just patient dumping. As one physician has stated:

[EMTALA's] relatively short statements, describing the institution's statutory duty, are drawn with such broad brush strokes that they have resulted in a wide variety of judicial interpretations regarding the precise nature and extent of a hospital's obligations to provide emergency medical care. This variance in the courts' rulings is a direct corollary of the failure of the statute's language to accurately reflect the legislative intent behind its enactments. Those courts that choose not to require proof of improper motive are challenged by the need to structure an alternative basis for the imposition of liability...²⁶²

When the Sixth Circuit's improper motivation requirement is withdrawn, EMTALA creates dilemmas for both hospitals and the intended beneficiaries of the Act.²⁶³ One problem for hospitals is the difficulty of knowing what exactly EMTALA proscribes and mandates. Hospitals acting in good faith might mistakenly break the law because its contours are undefined. This, in itself, makes portions of EMTALA fundamentally unfair. The language of the Act entails a significant

²⁶¹See Mark J. Garwin, *Immunity in the Absence of Charity: EMTALA and the Eleventh Amendment*, 23 S. ILL. U. L.J. 1, 5 (1998).

²⁶²*Id.* at 5-6.

²⁶³See Lowell C. Brown & Shirley J. Pain, *Patient Dumping by Specialized Care Facilities: Compliance Efforts Riddled with Uncertainties*, 9 No. 6 HEALTHSPAN 3 (1992) (discussing the uncertainties that hospitals face in attempting to interpret EMTALA's vague provisions).

violation of the American rule of law, in that the statute fails to lay down "the 'rules of the game' which enable individuals to foresee how the coercive apparatus of the state will be used, or what he and his fellow citizens will be allowed to do, or made to do, in stated circumstances."²⁶⁴ Undoubtedly, this will lead to economic waste (from which nobody benefits and which actually harms patients) as hospitals and physicians guess at what conduct is prohibited by the statute.²⁶⁵ In an effort to avoid liability, some hospitals will do too much by providing unneeded tests and treatment. Inevitably, however, some other hospitals will do too little. Their common-sense definition of an "appropriate" screening will differ from some courts' interpretations of the same term. Of course, this has already happened, resulting in hospitals facing EMTALA suits for conduct they could not have known was illegal under the vague standards of the statute.²⁶⁶

As the statute is judicially molded to take on a more definite form, interpretative problems will no doubt subside. But troubles with vagueness are being replaced by an even greater threat: liability for EMTALA claims merely alleging physician negligence, and not the intentional dumping of indigent individuals. Beyond the direct financial losses which hospitals will suffer, this phenomenon will shift the burden of malpractice onto hospitals and away from physicians, thereby reducing the incentive for physicians to avoid negligent conduct. Also, as mentioned above, some courts refuse to apply comparative fault principles to EMTALA actions,²⁶⁷ thus depriving hospitals of a liability-reducing device which they might normally enjoy in a state lawsuit for malpractice. While many will shed no tears for the hospitals (and their perceived deep pockets), the foolishness of this view is its failure to understand that hospitals will pass these costs on to the consumers. Some of these consumers are indigent (and are EMTALA's intended beneficiaries), and cannot afford to bear these

²⁶⁴FRIEDRICH A. HAYEK, *THE ROAD TO SERFDOM* 92 n.3 (Fiftieth Anniversary Edition 1994).

²⁶⁵"If the individuals are to be able to use their knowledge effectively in making plans, they must be able to predict actions of the state which may affect these plans." *Id.* at 84.

²⁶⁶See Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 3, 4 (1993) (noting that even ten years after EMTALA's enactment, attorneys debate the meaning of the statute's most basic terminology).

²⁶⁷See *Griffith*, 824 F. Supp. at 1364.

costs.²⁶⁸ Ironically, if EMTALA continues along this course, its own expansive language will diminish its ability to ensure that low-income patients receive emergency medical care. It is already working contrary to its purpose.

Hospitals, particularly those in poverty-stricken areas, are concerned that they will be unable to shoulder the financial burden of EMTALA.²⁶⁹ Since EMTALA's enactment, many emergency departments have closed their doors permanently, resulting in emergency care becoming more difficult for everyone to secure.²⁷⁰ Delayed treatment of the indigent was one ill EMTALA sought to cure. But the closure of emergency departments in hospitals will only add to this problem, as patients will be transported greater distances for emergency care.²⁷¹ As "patient access to high quality emergency care limits unnecessary deaths and injuries,"²⁷² EMTALA may actually be resulting in greater harm to some patients.

The closure of emergency departments, in turn, results in even greater pressure on the few urban hospitals which presently have the financial resources to maintain emergency departments.²⁷³ As discussed above, although it seems obvious that state hospitals enjoy Eleventh Amendment immunity from EMTALA lawsuits, the issue has not been completely settled by the courts.²⁷⁴ Because many inner-city hospitals are creatures of the state (and treat a large number of indigent patients), it is possible that these hospitals will not be subject to financial penalties for dumping patients because of the immunity they enjoy. Without this disincentive to dump needy patients (a disincentive that private hospitals cannot escape), some state hospitals may find it in their best financial interests to do so. This leaves open the possibility that inner-city state hospitals will, at best, legally burden private

²⁶⁸See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 409 (5th ed. 1998).

²⁶⁹See Lewis Diuguid, *Talk is Cheap in the Debate on Indigent Health Care*, KANSAS CITY STAR, Apr. 24, 1999, at 15.

²⁷⁰See EPSTEIN, *supra* note 22, at 96.

²⁷¹See Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 326 (1995).

²⁷²*Id.*

²⁷³See *id.* at 354 ("Suburban hospitals, linked by telemetry systems, are likely to pass patients on to hub hospitals with trauma units and substantial emergency department operations.").

²⁷⁴See Garwin, *supra* note 258, at 38 (opining that EMTALA will not withstand Eleventh Amendment immunity).

hospitals by dumping more patients onto them, and at worst, deny much-needed care to the indigent.

EMTALA's expanding liability has the potential to cause other evils. Consider, for example, the emergency patient who is completely insured and can afford the best care available. A transfer to another hospital with specialized care may be in his best interests. But because the patient might die in transport or might receive less than adequate care at the other hospital, the transferring hospital could be subject to an EMTALA lawsuit. The financially savvy hospital, seeking to reduce its chances of liability, might elect not to transfer patients as a matter of general policy, thereby denying patients the expertise and specialized care of the other hospital.²⁷⁵ Again, while there is no data to support these hypotheses, it seems that some of EMTALA's unintended consequences are analogous to the evils which Congress sought to prevent through the enactment of EMTALA. Not surprisingly, then, many physicians have criticized EMTALA, arguing that it is increasing the cost of providing care while decreasing the quality of care that patients receive.²⁷⁶

The Act's overbreadth also has other societal costs. For example, the OIG, HCFA, and state agencies are forced to investigate purported violations of EMTALA, whether they understand "patient dumping" in its original sense (*i.e.*, refusing to treat indigent emergency patients) or as it is construed under the broader terms of the statute. Thus, enforcement efforts are wasted on the hospitals which did not dump impoverished patients, but merely misdiagnosed or negligently treated a patient. Because these agencies have limited budgets, hospitals truly guilty of dumping will go unpunished while the inevitable acts of malpractice will be punished with federal civil fines, state civil fines, damage suits under EMTALA and comparable state statutory provisions, and state common law malpractice claims. Moreover, EMTALA's federalization of state malpractice law can hardly be in the best interest of our federal judicial economy,²⁷⁷ as federal courts are

²⁷⁵While it is true that EMTALA probably provides a cause of action for failing to transfer, there are no reported cases involving this claim, indicating that the chances of a claim for wrongful transfer are much greater than for failure to transfer.

²⁷⁶Mary McGrath, *Doctors Denounce Law on ER Patient-Dumping*, OMAHA WORLD-HERALD, Apr. 26 1999, at 10.

²⁷⁷This federalization of malpractice law also raised concerns about respect for state

already burdened by Congress's increasing tendency to federalize crimes.²⁷⁸ Further, it is "at least controversial to say that Congress has the power to federalize the tort of medical malpractice."²⁷⁹ In short, while nearly everyone concedes that Roberts was correctly decided, and was a victory for strict statutory construction, to the extent that it is a rejection of efforts to restrict the scope of EMTALA, its effect was not a victory for the constructors of the statute, state law, or the Act's intended beneficiaries. As commentators have noted, the statute itself is severely flawed:

EMTALA's flaws far exceed its limited virtues. The statute is sloppily drafted, and the most important words are undefined or defined far too broadly. The premise of the statute is silly at best; one cannot impose open-ended obligations of this sort on private parties and expect them to meekly comply, and the inevitable adaptive responses make everyone worse off. The private right of action effectively creates a federalized medical malpractice regime with the distinct tendency to reward the wrong people. When the federal government enforces EMTALA, its aims and tactics leave much to be desired.²⁸⁰

Recognizing these undesirable effects that EMTALA's overbreadth has engendered, some courts have sought to judicially modify the Act. Accordingly, some courts have refused to grant relief under EMTALA unless an individual could show that he was indigent when dumped,²⁸¹ or as in *Roberts*, that the hospital acted with an improper motive. While it is unquestionably beyond the judicial function to redress the shortcomings of EMTALA,²⁸² it is within the

sovereignty.

²⁷⁸For discussion of the evils of federalizing criminal law see Edwin Mease, III, *Big Brother on the Beat: The Expanding Federalization of Crime*, 1 TEX. REV. L & POL'Y 1, 3, 22 (1997).

²⁷⁹Louise Weinberg, *The Power of Congress Over Courts in Nonfederal Cases*, 1995 B.Y.U.L. REV. 731, 778.

²⁸⁰David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 30 (1998).

²⁸¹See, e.g., *Coleman*, 711 F. Supp. at 348; *Stewart*, 731 F. Supp. at 435-36.

²⁸²Of course, it is the duty of courts "to give effect to the intent of Congress." *Takao Ozawa v. United States*, 260 U.S. 178, 194 (1922).

courts' power to adopt a narrow, common sense interpretation of the statutory text to ensure that its purpose is served.²⁸³ The problem is not that courts misunderstand EMTALA's purpose, as they have generally recognized that "EMTALA does not create liability for malpractice based on a breach of national or community standards of care; at the core, it aims at disparate treatment."²⁸⁴ But the "mere declarations by the court[s] that the Act did not federalize malpractice does not change the fact that the determination of that which is 'reasonably calculated to identify critical medical conditions' will inevitably require expert medical testimony in a manner indistinguishable from malpractice litigation."²⁸⁵ Mere lip service to the idea that EMTALA is not a malpractice statute does the indigent no service.

The real task lies in devising standards based on the text of the Act which serve EMTALA's goal of preventing patient dumping, but which do not punish medical malpractice or at least minimizes EMTALA's intrusion into the malpractice field.²⁸⁶ Sometimes, less is better. Thus, in EMTALA's context this means limiting the scope of the Act to its text and purposes. Despite notions to the contrary, this limited scope is ultimately in the best interests of those who might need EMTALA's protections and all emergency patients who require prompt treatment. Not surprisingly, then, even those who object to the judicial limitation on private cause of action, whether or not they believe that these limitations are required by the statute, recognize that they are designed to achieve Congress's purpose in enacting EMTALA.²⁸⁷

Applying these principles to the familiar cases, in failure to adequately screen claims, courts should follow the majority of Circuits in rejecting a negligence standard of care,²⁸⁸ or its cousin, a standard

²⁸³ As the Supreme Court has stated: "We need not leave our common sense at the doorstep when we interpret a statute." *Price Waterhouse v. Hopkins*, 490 U.S. 228, 240 (1989).

²⁸⁴ *Brooks*, 996 F.2d at 713.

²⁸⁵ Garwin, *supra* note 258, at 16 (footnote omitted).

²⁸⁶ As one court noted, it is "inescapable that at least some EMTALA violations are medical malpractice claims." *Burks v. St. Joseph's Hosp.*, 596 N.W.2d 391, 401 (Wisc. 1999).

²⁸⁷ See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1142-43 (8th Cir. 1996) (Heaney, J., dissenting) ("In light of Congress' intent to address patient 'dumping' in enacting EMTALA, the majority is understandably frustrated by the plain language of the statute. Its limitation of the statute's application perhaps even meets Congress' objective than the law enacted by Congress").

²⁸⁸ See, e.g., *Holcomb*, 30 F.3d at 117; *Collins*, 963 F.2d at 307; *Gatewood*, 933 F.2d at 1039.

which requires courts to determine whether the examination was "reasonably calculated to identify critical conditions..."²⁸⁹ Requiring hospitals to meet these standards, while perhaps laudable on one level, is neither compelled nor suggested by the text or purposes of EMTALA.²⁹⁰ Furthermore, misdiagnosis (the essence of many failure to screen claims) is a common problem in American emergency rooms.²⁹¹ "Patients with apparently trivial complaints are often dismissed from emergency departments with their true conditions undiagnosed."²⁹² State medical malpractice law already provides a sufficient remedy for misdiagnosis, and thus a strong disincentive for such conduct. Not surprisingly, "over two-thirds of emergency medical malpractice suits involve the failure of the emergency physician to diagnose a condition."²⁹³ Thus, there is little need for EMTALA to regulate such conduct. While the federal government arguably has an interest in preventing patient dumping, an extensive "federal interest in malpractice is doubtful..."²⁹⁴ Thrusting EMTALA into the medical malpractice fray merely adds another layer of complication to the law.²⁹⁵ Thus, in failure to stabilize and transfer cases, the purposes of EMTALA are ill-served by foisting liability on hospitals that have no knowledge (and perhaps could not have knowledge) of a patient's emergency medical condition.²⁹⁶ By rejecting a negligence standard of

²⁸⁹See *Correa*, 69 F.3d at 1192.

²⁹⁰EMTALA "was not enacted to remedy negligent diagnosis..." *McIver*, 1999 WL 395391, at *1.

²⁹¹See RAYMOND M. FISH & MELVIN E. EHRHARDT, PREVENTING EMERGENCY MALPRACTICE 54 (1989).

²⁹²*Id.*

²⁹³*Id.*

²⁹⁴Gary T. Schwartz, *Considering the Proper Federal Role in American Tort Law*, 38 ARIZ. L. REV. 917, 922 (1996).

²⁹⁵See, e.g., *Derry v. Peskin*, No. 971720A, 1999 WL 1204013, at *4 (Mass. Super. Ct. Nov. 16, 1999). In *Peskin*, the Derrys sued the physician in charge of a hospital's Ob/Gyn department after their son was born dead. The Derrys claimed that Dr. Peskin violated EMTALA because his department failed to provide an appropriate screening, failed to stabilize the emergency medical condition, and improperly transferred Mrs. Derry while she was in labor. Although Dr. Peskin was not even present at the hospital when Mrs. Derry presented herself and was transferred, the court refused to grant summary judgment because "Dr. Peskin's responsibilities with regard to the Department's compliance with EMTALA may have created a personal duty to the Derrys." *Id.* EMTALA does not create liability for directors of medical departments who fail to instruct subordinates on the duties of EMTALA, so the *Peskin* court was incorrect to the extent it held otherwise.

²⁹⁶See, e.g., *Carodenuto*, 593 N.Y.S.2d at 446.

care for EMTALA claims, courts serve the purposes of the Act and help to minimize the overbreadth of the statute.

Courts could further serve the text of the statute by applying the Act's own prohibition of lawsuits except those by "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement" of EMTALA.²⁹⁷ As discussed above, a proper interpretation of this phrase would permit only those patients who were denied a screening or stabilizing treatment to sue for a violation of the statute. Any harm to the family is (1) not suffered by the individual patient; and (2) not a direct result (but only a secondary one) of the EMTALA violation. Judicial enforcement of this limitation would, therefore, preclude wrongful death actions to the extent they compensate the decedent's family and not the EMTALA victim. Furthermore, using this proviso, courts could dismiss actions seeking damages for emotional pain to the family of the patient, as the individual patient's harm is the only harm compensable under the terms of the statute.

Some courts have suggested imposing a temporal limitation on the stabilization requirement.²⁹⁸ As the First Circuit noted: "Requiring hospital-wide stabilization of individuals with emergency medical conditions raises the question of how long subsection (b)'s stabilization obligation persists. If stabilization were mandated by EMTALA without limit of time, it might well encroach upon the province of state malpractice law."²⁹⁹ Thus, the Fourth Circuit has held that "the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient..."³⁰⁰ This temporal limitation seems to be implicit in the text of the statute, as the obligation to stabilize arises immediately after the hospital "determines that the individual has an emergency medical

²⁹⁷42 U.S.C. § 1395dd(d)(2)(A) (1994).

²⁹⁸See *Lopez-Soto*, 175 F.3d at 177 n.4; *Bryan*, 95 F.3d at 352.

²⁹⁹*Lopez-Soto*, 175 F.3d at 177 n.4.

³⁰⁰*Bryan*, 95 F.3d at 352.

condition.”³⁰¹ As a secondary consideration, this limitation is certainly in accordance with the original purpose of EMTALA.³⁰²

Beyond serving EMTALA's purposes and curing overbreadth, these limitations and standards help prevent the needless cluttering of the courts with lawsuits seeking to punish unintentional and sometimes unpreventable misdiagnoses and treatment based on misdiagnoses. Such lawsuits serve no purpose other than to bring EMTALA into disrepute among those who are governed by it. While some might find this a minor point, hardly worth mentioning, because hospitals and physicians have powerful congressional lobbyists (by which these and similar laws may be repealed), it is important to the purposes of EMTALA that this law have at least a semblance of reasonableness. Laws which are applied in an overly expansive fashion face a greater danger of legislative repeal or amendment, or as in the case of *Roberts*, judicial amendment.³⁰³ This is not to say that some tinkering with EMTALA would not produce beneficial consequences for all parties involved—hospitals, physicians, patients, lawyers, the courts and taxpayers. In fact, many lawyers have suggested various ways to amend EMTALA.³⁰⁴ Among the more palatable suggestions is the

³⁰¹42 U.S.C. § 1395dd(b) (1994).

³⁰²But recall that it was the desire to serve that original purposes of EMTALA that got the appellate panel in trouble in *Roberts*. Importantly, the temporal limitation has more than this to hang its hat on, as the text of the statute seems to presuppose this limitation. Thus, this caveat is distinguishable from the motive one employed in *Roberts*.

³⁰³There has been a suggestion that Congress amend EMTALA to require proof of an economic motive. See Thomas L. Stricker, Jr., Note, *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121, 1122-23 (1992) (suggesting that the Act be amended to require proof of economic motive). But judging motives is always difficult. A better approach would make proof of indigence an element of an EMTALA claim.

³⁰⁴See, e.g., GEORGE J. ANNAS, SOME CHOICE: LAW, MEDICINE, AND THE MARKET 85 (1998) (“Congress should have included the phrase ‘consistent with reasonable medical standards’ in its requirement for patient stabilization in the emergency department.”); Mark Strasser, *The Futility of Futility?: Life, Death and Reasoned Public Policy*, 57 MD. L. REV. 505, 509 (1998) (suggesting that Congress amend the Act to “clarify what it intends EMTALA to include” such as “specifying that the Act is intended to apply only to indigent care”); Singer, *supra* note 17, at 160 (amend the Act to define “appropriate screening examination” as one that is free from gross misconduct); Scott B. Smith, Note, *The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After In the Matter of Baby K*, 48 VAND. L. REV. 1491, 1527-28, 1529 (1995) (“Congress should amend its sloppy legislation,” by eliminating “the inconsistency between the Act’s original intent and its statutory language”); Rosenstein, *supra* note 19, at 291 (Congress should improve definitions of terms).

requirement that a plaintiff prove his indigence as an element of an EMTALA claim. Further, practitioners and hospitals would warmly receive definitions of such terms as "appropriate medical screening examination" which reflect Congress's intent to protect the uninsured. Thus, an appropriate medical screening could easily be defined as a medical examination of such type and quality as the hospital or physician in question would normally give to similarly situated patients without regard to the patient's financial or insurance status. Finally, a "conscience" provision which protects physicians and hospitals for refusing to perform practices they consider morally repugnant would also prevent senseless lawsuits.³⁰⁵

Assuming that Congress will not amend the Act in the near future,³⁰⁶ courts must apply EMTALA so as to achieve its purpose as they are embodied in the text of the statute. In performing this task, the courts must avoid the temptation, highlighted in *Roberts*, requiring plaintiffs seeking to establish an EMTALA claim to allege elements not contemplated by the text of the statute.³⁰⁷ At the same time, the temptation of other courts to expand the reach of EMTALA to the domain of state malpractice law and beyond must similarly be curtailed. Emergency medical care is a vital part of the American health care system. EMTALA has the potential to ensure that the indigent receive the same emergency care that paying patients receive. At the same time, the legal and medical societies must realize that the Act has necessary limitations, and that it cannot be expected to cure emergency medical malpractice.³⁰⁸ Only when these limitations are recognized will the force of EMTALA be brought to bear on the evils of patient dumping.

³⁰⁵See generally Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177 (1993) (discussing the need for "conscience clauses" in statutes and regulations).

³⁰⁶This is a safe assumption. Rather than rushing to fix a broken statute, Congress is proposing new legislation which incorporates by reference the vague language of EMTALA. See Access to Emergency Medical Services Act of 1999, S. 517, 106th Cong. § 2 (1999) (incorporating by reference EMTALA's requirement of an appropriate medical screening examination).

³⁰⁷As mentioned above, the Sixth Circuit still requires plaintiffs in screening cases to allege an improper motive, despite the fact that there is no textual support for this requirement. See *Estate of Taylor*, 1999 WL 519295, at *2.

³⁰⁸As many courts have repeated time and again, "'EMTALA' is not a federal malpractice statute." *McIver*, 1999 WL 395391, at *2.

